THE EFFECT OF GENDER ON HIV-RELATED STIGMA AND DISCRIMINATION: CASES FROM TURKEY

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Approval of the Graduate School of Social Sciences

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ABSTRACT

THE EFFECT OF GENDER
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This study explores the effect of gender on HIV-related stigma and discrimination with selected cases from Turkey and examines 'normalized sexuality' (i.e., conformity to sexual norms in Turkish society) as a moderating factor. In this regard, both qualitative and quantitative data collection techniques have been utilized, namely; (i) in-depth interviews with HIV positive women and men with different sexual lives, and (ii) a survey conducted at the University of Istanbul among dentistry students.

The main quantitative findings of the research include (i) sexual loyalty of a woman was found as a determinant for HIV-related stigma and discrimination; (ii) female respondents discriminated people living with HIV on the basis of normalized sexuality; and (iii) male respondents discriminated on the basis of sex of the person living with HIV. A surprising secondary finding was that the sexual orientation of an HIV positive male did not significantly affect the amount of discrimination.

These quantitative findings were also supported by the qualitative findings and all were analyzed with a gender perspective. Gender norms and sexual behaviors in Turkish society are shaped strongly by the patriarchal power structures, and stigma and discrimination act as control mechanisms to sustain this structure. It is thus argued that the prevailing patriarchal values and norms need to be examined in order to effectively challenge HIV-related stigma and discrimination.

Keywords: HIV, AIDS, gender, stigma, discrimination

ÖZ

TOPLUMSAL CİNSİYETİN
HIV İLE İLGİLİ AYRIMCILIK VE DAMGALAMAYA ETKİSİ:
TÜRKİYE'DEN ÖRNEKLER

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Bu çalışma, toplumsal cinsiyetin HIV ile ilgili ayrımcılık ve damgalamaya etkisini incelerken, Türkiye'deki normalleştirilmiş cinselliğin (toplumdaki cinsel normlara uyum) bu etki üzerindeki ılımlaştırıcı etkisine bakmaktadır. Bu bağlamda, çalışma kapsamında hem niteliksel hem de niceliksel veri toplama teknikleri kullanıldı, şöyle ki (i) değişik cinsel davranışları olan HIV pozitif kadın ve erkekler ile derinlemesine mülakatlarla (ii) İstanbul Üniversitesi Diş Hekimliği Fakültesi öğrencileri arasında bir anket çalışması yapıldı.

Niceliksel araştırmanın ana sonuçları şunları gösterdi ki: (i) kadının cinsel sadakati, HIV ile ilgili ayrımcılıkta belirleyici bir faktör olarak bulundu; (ii) kadın katılımcılar HIV ile ilgili ayrımcılıkta normalleştirilmiş cinselliği esas alırken (ii) erkek katılımcılar HIV ile yaşayanın cinsiyetine göre ayrımcılık yaptılar. İkincil ve ilginç bir bulgu ise, erkeğin cinsel oryantasyonunun, ayrımcılıkta anlamlı bir fark

yaratmadığıydı. Bu niceliksel bulgular, mülakatlardan elde edilen niteliksel bulgularla da desteklendi ve sonuçlar, toplumsal cinsiyet bakış açısı ile incelendi. Toplumsal cinsiyet normları ve Türk toplumundaki cinsel davranışlar ataerkil güç yapıları tarafından şekillendirilmekte ve ayrımcılık ve damgalama bu yapıyı devam ettirmek için kontrol mekanizmaları olarak işlev yapmakta. Bu nedenle, HIV ile ilgili ayrımcılık ve damgalamaya daha etkin karşı çıkabilmek için, mevcut düzende hüküm süren ataerkil değerlerin ve normların incelenmesi gerektiği tartışılmaktadır.

Anahtar kelimeler: HIV, AIDS, toplumsal cinsiyet, ayrımcılık, damgalama

To My Husband

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I would like to extend my thanks to Peter, my husband, who has been providing me his continuous support for my personal and professional growth. He is the one who I can question and challenge the established norms and beliefs with and open new doors together for better understandings in life.

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CHAPTER 1

INTRODUCTION

1.1. Background

Until one meets a person who lives with HIV or contracts the virus, it is hard to realize the challenges that people living with HIV (PLHIV) face. Life may become quite difficult such that the HIV positive person can lose the societal network or support structures that we all take for granted. For example, the person may not be able to receive health care from most doctors, find a dentist who would want to provide treatment, stay at a hotel, swim in a public pool, travel to some countries, go to school or work with other people. The environment that the person lives in becomes smaller as the person reveals his/her HIV status to more and more people, including friends, family, co-workers, market sellers, teachers, and many others. The stigma and discrimination exerted by the society lowers the quality of life of people living with HIV; people not only deal with the burden of the infection, but they also lack support from their communities, probably when they need it the most.[1]

The mechanisms of HIV-related stigma and discrimination are quite complex and they are still being investigated. Due to some factors such as promiscuous and unconventional sexual behaviors and marital status, some people living with HIV can be more stigmatized and discriminated than others. Researchers argue that HIV-related stigma is moderated by societal factors and sexual norms in society and it is perpetuated by the pre-existing stigmas (Gilmore and Somerville, 1994; UNAIDS, 2000; Parker et al, 2002; ICRW, 2005). People living with HIV are often blamed for their condition and judged in moral rather than medical terms (ICRW, 2005; APN+

[1] These examples are all based on real-life experiences of people living with HIV that I have met through my work with the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Turkey.

2002). As revealed by these studies, the HIV-related stigma and discrimination is not that simple, not just due to the virus or the infection itself, but rather because it is attached to sexuality, which is one of its routes of transmission.

Studies have also commonly found that HIV positive women are treated differently, discriminated at a higher degree than men, blamed and isolated from their social environment in many cases (UNAIDS, 2000; ICRW, 2005; APN+, 2004). For example, it was found that promiscuous sexual behaviors of men who contract the virus are likely to be excused and justified, or overlooked in the society, whereas this is not the case for women (UNAIDS, 2000; PANOS, 2001). Women are held responsible in most cases to uphold the moral traditions of their societies (ICRW, 2005). Therefore, the role of gender has been shown to have an impact on the HIV-related stigma and discrimination against women in these studies.

Gender, which is a socially constructed status through psychological, social and cultural mediums (West and Zimmerman, 1991), shapes beliefs, knowledge, attitudes and behaviors of men and women in societies. The existing power structures[2] affect the construction process and the recipes for gender are given from birth and reconstructed over the years to sustain the existing power structures in the society. Gender-related stigma and discrimination shows itself such that both negative and positive values (i.e., devalued and valued) are utilized to shape the behaviors of the members of the society within the patriarchal structures.

One of the related concepts to gender is sexuality[3] when we discuss HIV-related stigma and discrimination. Sexuality refers to reproduction and eroticism (Beasley, 2005) and authors discuss that defining sexuality has changed its focus from reproduction within families to physical pleasure of individuals and emotional intimacy; the activities and values given to sexuality including procreation of children, eroticism, personal intimacy and power over the others have gained

[2] These power structures are described in much detail in Chapter 3.

[3] There are authors arguing on using the term 'gender' against 'sex' and 'sexuality', whereas there are others who think that 'gender' is inseparable from 'sex' and sexuality' and they are all interconnected. These views also show themselves in debates on three subfields of gender/sexuality theory, which is Feminism, Masculinity and Sexuality studies (Beasley, 2005).

importance based on the powers in societies at different eras (D'Emilio and Freedman, 1997).

Similar to gender, sexuality is constructed in societies and can be changed over time. Weeks (1994) defines construction of sexuality as an end product of the interaction between the person's being and the society's concern on the members, including moral uniformity, economic and social security and health. As the society gets more and more involved with the lives of the members due to reasons such as hygiene, health, moral uniformity, it becomes more focused on disciplining the bodies with the sexual lives of its members. Therefore, different societies may choose to focus on the sexual lives of its members by looking at different aspects, such as moral uniformity, hygiene, etc. Sexuality then becomes a tool of power in societies such as imposing various sexual rules and associating some sexual behaviors with morality and sin to stop some unwanted sexual behaviors (Davenport-Hines, 1990; D'Emilio and Freedman, 1997).

Control of sexual behaviors, especially towards women, has been commonly seen in history (D'Emilio and Freedman, 1997). Some sexual behaviors, such as sexual relationship out-of-wedlock, have been unacceptable for women in many cultures (UNAIDS, 2000). As women disobey, then stigma and discrimination come into the picture to exert power and control this unwanted behavior. In other words, there is an unequal power structure such that this norm has been built by dominant powers in the society and aims to control women's sexuality.

Therefore, when we discuss about the effect of gender on HIV-related stigma and discrimination, we must then examine the unequal power structures that underlay gender relations in societies, and how these shape our norms, beliefs, values, attitudes and behaviors. This study aims to understand the embedded power structures that underlay the HIV-related stigma and discrimination by examining how gender is a structure of unequal power relations between men and women, and how normalized sexuality moderates the stigmatization and discrimination process. This study will discuss the manifestations of HIV-related stigma and discrimination in Turkish society by examining works on stigma and discrimination, sexuality,

normality, and the unequal power relations between men and women. In order to achieve this, this study analyzes works of authors from various fields, including sociology, psychology, medicine, anthropology and gender and women's studies.

1.2. The Research Procedure

This work originated through my experiences with people living with HIV during the time I worked for the Joint United Nations Program on HIV/AIDS (UNAIDS) in Turkey.[4]

Knowing that HIV positive women are blamed and discriminated at a higher degree than men in many other countries in the world, I observed a similar but somehow different manifestation of HIV-related stigma and discrimination in the Turkish society. For example (i) married HIV positive women do not get blamed in Turkey for bringing the virus home and it is assumed that men are the ones who contracted the virus first. This observation is opposite to the findings of research in Africa or in India (e.g., ICRW, 2005; UNAIDS, 2000); (ii) married HIV positive women are protected, accepted by family and friends, receive a lot of support, and again this is different than the findings in various countries (e.g., APN+, 2004; ICRW, 2005; PANOS, 2001; UNAIDS, 2000); (iii) some single HIV positive women have HIV negative boyfriends, they are accepted by family and friends and this acceptance is quite contradictory to the findings of some research where HIV positive women are blamed for contracting the virus out-of-wedlock and are highly discriminated (e.g., APN+ 2004; ICRW, 2005). In addition to these observations on HIV positive women, I have also seen that (iv) if married men contract the virus, even though men are assumed to bring the virus home, they are accepted by family and friends in Turkey and not blamed as much for contracting the virus, and this observation is similar to the findings of research conducted in India, or Africa (e.g., UNAIDS, 2000; ICRW, 2005) (v) all heterosexual men I have met had no difficulty revealing

[4] While doing a literature research for the current study, both as a professional and a researcher in the field of AIDS, I have observed my own stigmas that I had had developed and possessed towards various issues in life, both as a dentist and as a woman grown up in a patriarchal society. This current study combined with my professional work has become my own learning journey in understanding stigma and discrimination towards those who are oppressed in societies, such as women, homosexuals, and people living with HIV. I have also realized that power is the fundamental concept to challenge if we want to help humanity in the world.

their status to family and friends whereas most homosexual men have difficulty revealing their HIV status. This may indicate that the case for men may also be different in a homosexual context in the Turkish society.

Upon discussing my observations with my thesis supervisor, Prof. Ertürk, I realized that I had to look into normalized sexuality in Turkey to be able to understand the reasons behind my observations as listed above. My discussions with men and women living with HIV helped shape my thesis, which started my learning journey for studying the effect of gender on HIV-related stigma and discrimination by examining the inherent power dynamics.

In the case of Turkey, patriarchal norms of sexuality are rigidly upheld in most parts of the Turkish society and usually men enjoy freedom in sexuality[5]; for example men are encouraged to experience sexuality before marriage and their behavior is overlooked if they fail to be loyal to their wives when married. Promiscuity of heterosexual men is considered "normal" in the Turkish Society (İlkkaracan, 1998; İlkkaracan and Seral, 2000; Cindoğlu, 2000). For example, if a married man has an affair with a woman, it is considered as an "accident" and "*he couldn't resist his instinctual manly behavior*" (in other words, he did not really mean it), and thus should be forgiven. Men's promiscuous sexual behavior is justified in any case; men who act like playboys (*çapkın*) are admired since their affinity to women is perceived as demonstrating their "manhood". This is the constructed male sexuality norm in

[5]It should be noted that this is a universal dimension of patriarchy. Despite the sexual revolution and despite the sexual freedom gained by women since 1960's, women who are sexually free are still judged differently than men. Ertürk (2004a) in her article 'Considering the Role of Men in Gender Agenda Setting' argues that this differential approach to male/female sexuality is historically linked to women's reproductive capacity and direct link to both the mother and the child, therefore, justifying the control of men over women's sexuality. Ertürk also highlights the fact that the contraceptive use today has eased the relation between both reproduction and sex and DNA testing has eased the worry about paternity. In this context, in countries like Turkey, upper class women also enjoy such freedom.

It should also be noted that the feminist movement in the last two decades in Turkey has contributed a great deal towards making a paradigm shift. Turkey, being a candidate country for the European Union, has had to change much legislation for achieving gender equality (such as honor crimes, virginity tests, etc.). However, the existing patriarchal structures are very strong that the implementation of the legislative changes will take a long time to be actualized by the citizens of the country.

the Turkish society.[6]

However, this norm is not the case for women. There is strict control over women's sexuality in the Turkish society, as demonstrated by the importance of virginity at the time of marriage (Anıl et al, 2005; Cindoğlu, 2000). The girl is protected by the father of the family until the wedding night and then is transferred to the hands of the husband. Women's sexuality out-of-wedlock is not approved, and penalized if not obeyed; thus women's sexuality is only normalized within wedlock, and with her husband only (Cindoğlu, 2000; İlkkaracan, 1998). This is the constructed norm for women in the Turkish society.

Therefore, given such gender constraints in the Turkish society, when a married woman contracts HIV, it is almost always assumed that it was the man who brought the virus home and thus the married woman would be perceived innocent.[7] Under rigid patriarchal control over women's sexuality, it is likely that HIV positive women will not be condemned- as the Turkish case shows. However, more comparative research is needed to ascertain whether this is a general trend or specific to Turkey. One additional aspect of this study is that whether men's sexual orientation moderates the HIV-related discrimination in Turkish society and that if men would be blamed for contracting HIV when they do not follow the sexuality norms of the culture.

Thus, with this current research, I aim to (i) understand HIV-related discrimination with reference to sexual behaviors of men and women by referring to the sexual norms in the Turkish society and (ii) examine women's HIV-related discrimination within the framework of this patriarchal structure in Turkey.

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[6] This norm has been embedded to various Turkish sayings, such as '*çapkınlık erkeğin elinin kiri*' (act of being a playboy is only a dirt on man's hand) , '*erkeğin eli kınası, kahpenin yüzü karası*' (henna on man's hand, black mark on prostitute's face), both indicating that men's sexual enjoyment does not stay as a permanent mark with him and disappears as if he washes dirt off his hand.

[7] The below quotation is illustrative: *"Unfortunately,* w*e see that the doctors categorize the HIV positive patients as good patients and bad patients. The good ones are the ones who contract the virus innocently, so to say, such as women who contract the virus from their husbands and children…"* Statement made by Prof. Dr. Serhat Ünal, the Head of Hacettepe University AIDS Treatment and Research Center in Ankara, Turkey, at the UNAIDS Regional Consultation Meeting held in Romania, February, 2006.

I have utilized the "normalized sexuality" concept in the Turkish society to be able to understand the effect of gender on HIV-related discrimination and stigma. Based on observing real-life experiences of people living with HIV, this study hypothesizes that gender has an impact on HIV-related stigma and discrimination and "normalized sexuality" acts a moderating factor for HIV-related stigma and discrimination in the Turkish society. The predictions of the study were that (i) women's loyalty to a monogamous relationship would be a determining factor for HIV-related stigma and discrimination; (ii) men's sexual orientation will be a determining factor for HIV-related stigma and discrimination, (iii) HIV positive women and men who conform to the norms of sexuality (sexuality within marriage for women, and heterosexual promiscuity for men) will be perceived differently compared to those who are "deviant" (i.e., promiscuous sexual behavior for women and homosexual orientation for men).

For testing these propositions, both qualitative and quantitative data were collected and compared. (1) Qualitative data was collected through in-depth interviews with four people living with HIV who have different sexual experiences. Two of these people are women; one who lives in conformity to the sexual norms of the culture and the other who doesn't. The other two are men; one heterosexual (who follows the sexual norms of the society) and one homosexual (who doesn't). (2) Quantitative data was collected through a survey based on a self-administered questionnaire among 253 university students (127 males, 126 females) at Istanbul University Faculty of Dentistry. The survey aimed to capture the knowledge, attitude and behavior of the respondents with respect to HIV. The respondents received an experimentally designed questionnaire based on four different scenarios to test their responses, and each respondent received one version of the scenario randomly (four scenarios total). Each scenario included a man or a woman (two men and two women in total) with different sexual lives and living with HIV, similar to the people interviewed. That is, two of these characters in the scenario were women: one who exhibits the approved sexual behavior of the culture and the other who doesn't; and two men: one heterosexual (who exhibits culturally approved sexual behaviors) and one homosexual, who doesn't. The characters in the scenarios were kept parallel to the people interviewed. Upon reading the scenario, the respondents learned that the

character (who is assumed to be their friend) just found out that he/she was HIV positive. This was followed by a series of questions in order to understand the respondents' attitude and behaviors based on the sex and sexuality of the person in the scenario, as well as their knowledge on HIV/AIDS.

The results provided support to the hypothesis that (i) HIV positive women who display "normal" sexual behaviors (i.e., sexuality only within marriage) were discriminated significantly less than women who display promiscuous or "deviant" behaviors, and also were discriminated significantly less than men who display either normal or deviant sexual behaviors, (ii) "normalized sexuality" appeared to be a moderating factor for HIV-related discrimination, however this result was significant only for female respondents, (iii) unexpectedly, HIV positive women were discriminated less than HIV positive men by the male respondents, (iv) the sexual orientation of men living with HIV did not seem to be a significant determinant with respect to HIV-related discrimination. The above results were also supported by the qualitative findings.

This study aims to contribute to the knowledge in the field by looking at the gender dimension of HIV-related discrimination in Turkey in the context of normalized sexuality. This study aims to (i) enhance the understanding of the role of gender and hidden mechanisms that moderate stigma and discrimination towards people living with HIV in Turkey; (ii) contribute to the global debates on gender and HIV-related stigma and discrimination; and (iii) provide insight for practitioners and advocates in gender and HIV/AIDS fields to design better stigma reduction programs on AIDS.

This thesis consists of six chapters. Chapter II provides a historical and conceptual background on AIDS and HIV-related stigma and discrimination. The chapter discusses the role of gender in history of AIDS in terms of feminization of the epidemic and how gender inequality has increased the spread of HIV. This is followed by examining the history of syphilis to demonstrate how humans discriminated against syphilitic patients in a very parallel manner to HIV/AIDS, for 500 years in history. By providing these brief backgrounds, I have tried to demonstrate the inadequate response of humanity to both AIDS and syphilis, and

highlighted the reaction to sexual behaviors and stigmatic and discriminatory response of the society.

The third chapter examines norms and normality, how societies construct norms and keep them in place by using various tools of control. Stigma and discrimination act as tools to keep the existing norms in place and sustain the existing power structures. Patriarchy, being a universal power, is discussed to demonstrate its role in keeping the sexual norms in place and gender as means of the patriarchal power. Normalized sexuality within the gender construction in Turkey is then discussed to examine the power relations within the patriarchal structure and culture in Turkey.

The fourth chapter presents examples from the world and observations from Turkey on the manifestations of HIV-related stigma and discrimination in order to summarize all the discussions and proceed to the study procedure of this thesis. This chapter demonstrates how the HIV-related stigma and discrimination takes its roots from the patriarchal power relations and structure.

The fifth chapter presents the procedure of the qualitative and quantitative techniques utilized, the research results and corresponding discussions with respect to the effect of gender on HIV-related stigma and discrimination in Turkey.

The thesis ends with a discussion of the main research outcomes and provides recommendations for future studies.

CHAPTER 2

HISTORICAL AND CONCEPTUAL BACKGROUND

2.1. History of AIDS and HIV-Related Stigma and Discrimination

When the *Acquired Immunodeficiency Syndrome* (AIDS) was first seen among gay populations in the USA in the early 1980s, AIDS was identified as a sexually transmitted infection among gays. In 1983, the cause of AIDS was found to be the *Human Immunodeficiency Virus* (HIV) (UNAIDS, 2006) and the world later witnessed that this virus could also affect heterosexual men, women and children, and could kill millions of people in a short time. Since the first AIDS case was reported in 1981, 25 million people have died world wide and about 15 million children under age 18 have lost one or both parents to AIDS (UNAIDS, 2006).

The AIDS epidemic was perceived as an enemy in the world to fight against; as the modes of transmission[8] were identified, programs have been designed accordingly to control this epidemic. Currently, there are 40 million people living with HIV in the world, 95 % of which are in developing countries (UNAIDS, 2006). Even though medications have been found to reduce the level of virus in blood, there still is no real cure for AIDS (see Figure A1 in Appendix A which presents a summary graph on the history on AIDS).

When the world leaders came together at the 42nd Session of the UN General Assembly in 1987, the Director of WHO, Jonathan Mann, stressed the social aspect

[8] Modes of transmission include sexual contact, blood and blood products including injecting drug use, and mother to child.

of HIV and AIDS (Mann, 1987).[9] Mann, in his speech, stressed that besides the HIV epidemic and AIDS epidemic, the world was facing a third kind of epidemic which is formed by stigma and discrimination towards HIV and AIDS. Attention has been raised to the stigma and discrimination by many authors (Herek and Glunt, 1988; UNAIDS 2000; Parker et al, 2002; Ertürk 2005) and stigma was shown to affect not only people living with HIV but also their relatives and as well as their communities (APN+, 2004; ICRW, 2005). AIDS related discrimination appeared in societies, unknowingly based on fear, such as excluding HIV positive children at schools, or institutionalized, such as deporting migrant women upon finding out their positive status.

The international community acted to lower or eliminate HIV/AIDS related stigma and discrimination by adopting declarations and resolutions on HIV/AIDS and human rights (UNAIDS, 2000).[10] However, dealing with the epidemic became a challenge for the world despite all the efforts, resolutions, and commitments made. The common responses to AIDS have included fear, denial and ignorance (Herek and Glunt, 1988; UNAIDS, 2000). It was predicted that AIDS would not only have an immense effect on world health, but it would also have a strong effect on perceptions of sexuality, on sexual practice and on political life (Davenport-Hines, 1990: 2). Due to its routes of transmission, many in the world associated AIDS with improper

[9] As shown in Figure A1 in Appendix A, AIDS was defined in 1982 and HIV was identified in 1983. As Mann said (1987), the 42nd General Assembly meeting was almost 6 years after the efforts of the authorities working in the field to combat HIV/AIDS.

[10]- London Declaration (1988): "Discrimination against, and stigmatization of, HIV-infected people and people with AIDS and population groups undermine public health and must be avoided." (par. 6),
- 41st World Health Assembly Resolution (1988): (WHA 41.24) urged member states to develop a spirit of understanding for people living with HIV and AIDS, recommended the states to protect the human rights and dignity of those living/affected by HIV, discourage discrimination and stigmatization during travel, work, provision of services.
- UN Centre for Human Rights Consultation (1989): HIV/AIDS related discrimination and stigma should be prevented for the purposes of public health.
- UN General Assembly Resolutions (1990, 1991): confirm the 1989 Human Rights Consultation.
- The Second International Human Rights Consultation (1996): 12 international guidelines were drafted emphasizing the need to avoid HIV/AIDS related discrimination.
- Resolutions 1995/44 and 1996/43: Discrimination against people living with HIV/AIDS, or people perceived to be under high risk, is legally prohibited.
- Resolution 49/1999: reaffirms that actual or presumed HIV/AIDS related discrimination is prohibited by existing international human rights standards.

sexual behavior, and religious, cultural and traditional values have been reinforced to attempt to reverse the epidemic (PANOS, 2001; Sontag, 2001; ICRW, 2005).[11]

AIDS was associated with sin and people contracting HIV became scapegoats and announced on media. For example, the Daily Express in the UK dated 13 December 1986, included view of a citizen on people living with HIV in an article which may well reflect the views of many at the time: "*The homosexuals who have brought this plague upon us should be locked up. Burning is too good for them. Bury them in a pit and pour on quick-lime*" (Davenport-Hines, 1990:1). The homosexual men formed a large percentage of all cases up to 1988 and homosexuals and people with venereal diseases were seen as "dirty, dangerous and contagious" (Davenport-Hines, 1990:2). In some cases, AIDS related stigma resulted in violence against PLHIV in many parts of the world (e.g., Busza, 1999). A most striking case was the murder of a woman, Gugu Dhlamini, who was stoned and beaten to death by her neighbors in South Africa, upon revealing her HIV status on the World AIDS Day in 1998 (UNAIDS, 2000)--AIDS became another reason for justifying violence towards women.

Based on the need of understanding the mechanisms behind HIV-related stigma and discrimination, a general research protocol was developed with the initiative taken by the World Health Organization (i.e., former Global Programme on AIDS) in 1994, and this helped number of studies increase. The research focused on the definition of HIV/AIDS related discrimination and stigma, perception across different cultures, its forms and its main causes, the responses to it, and most appropriate research methods for analyzing and understanding it (UNAIDS, 2000).

Research on stigma and discrimination has been conducted in many parts of the world, for example in Uganda and India (UNAIDS, 2000), Tanzania, Zambia, Ethiopia and Vietnam (ICRW, 2003 and 2005), Botswana (Letamo, 2003), Indonesia, Phillippines, India, Thailand (APN+, 2004; Bharat and Aggleton, 1999),

[11] The mode of transmission appeared to become a factor to stigmatize people living with HIV (i.e., people first check about how the virus entered into the body, such as through an improper behavior or an accident) and then either judge the person as guilty and discriminate him/her or find the person innocent.

Uganda and Burundi (ACORD, 2004). Research has assessed that HIV and AIDS related stigma and discrimination is universal, occurs everywhere in the world (e.g., Alonzo and Reynolds, 1995; APN+, 2004; ICRW, 2005; UNAIDS, 2000, etc.) and is caused by many factors including lack of understanding, incorrect beliefs, lack of treatment, lack of cure, fears related to sexuality and fear of death (Aggleton and Parker, 2003).[12] The roots of HIV related stigma were linked to the currently existing stigmas and power relations in the society such as race, ethnicity and religion (Gilmore and Somerville, 1994; Aggleton, 1999; Parker et al, 2002; ICRW, 2005) [13]. People were blamed for contracting HIV, gender was identified as an important issue; and women, already having the subordinate position in the society, were found to be stigmatized and discriminated to a greater extent than men (e.g., ACORD, 2004; Bharat and Aggleton, 1999; ICRW, 2005; Ertürk, 2005, etc.).

2.2. Gender and HIV/AIDS

Even though AIDS was identified among men in the 1980's in California, the infection rates have increased among women and young girls all around the world dramatically, especially in Sub-Saharan Africa. In 1997, 41% of people living with HIV in the world were women, and as of December 2006, this rate has reached 50% (UNAIDS, 2006; Gender and HIV/AIDS, 2005). The infection rates among women were found to be on the rise in Asia (30%), North America (25%), Latin America (36%), Eastern Europe and Central Asia (34%) and the Caribbean (49%). The feminization rate of the epidemic is the highest in sub-Saharan Africa, where 75% of

[12] Stigma is now accepted as a barrier for prevention, treatment, support and care efforts. For example, (i) people avoid getting tested due to the fear of being stigmatized and discriminated; (ii) if they find out their positive status, they feel pressured to continue their regular behaviors not to reveal their status (e.g., men continue to have sex without condoms, women feel pressured to get pregnant or breastfeed their children), (iii) they have difficulty in receiving adequate support and care (e.g., their medical treatments are either delayed, or canceled), (iv) they live isolated in social environment. Especially the marginalized populations (e.g., sex workers) become the scapegoats for the infection and are stigmatized even further (e.g., APN+, 2004; ICRW, 2005; UNAIDS, 2006). Sex, dirt, fear, and punishment became the themes in AIDS-related stigma (Davenport-Hines, 1990: 3).

[13] Authors provided recommendations on how to eliminate the HIV related stigma (ACORD, 2004; Parker et al, 2002; Brown et al, 1995 and also 2003; Busza, 1999; Gilmore and Somerville, 1994; ICRW, 2005). Researchers also found that there are many unknowns remaining in the stigma reduction programs with respect to the gendered impact of the stigma reduction interventions (Brown et al, 2003).

young people living with HIV are women and girls (Gender and HIV/AIDS, 2005).[14] Considering that 70% of the world wide infections were occurring through unprotected sexual intercourse, the women and young girls were found particularly vulnerable due to their biology, economic and social inequalities and cultural and gender roles (Ertürk, 2005; UNDAW, 2000).

The feminization of the epidemic in 1990s raised attention to the gender issues among the international community and highlighted the subordinate status of women. In 1995, the urgency for taking a gender sensitive approach to combat HIV/AIDS (i.e., applying a gender perspective[15] on the social, developmental, and health consequences of HIV/AIDS and sexually transmitted diseases) was articulated at the 4th World Conference on Women in Beijing and was included in the Beijing Platform for Action. Many repeated discussions on gender issues such as the vulnerability of young women in the context of prostitution, trafficking in women and girls, health education, lack of statistical data on HIV/AIDS, and risks of mother-to-child transmission were discussed at the meetings of the Commission on the Status of Women (CSW) including the ones held in 1996, 1997, 1998 and 1999 (UNDAW, 2000).[16]

These meetings were followed by the 23rd Special Session of the General Assembly which was on "Women, 2000: Gender Equality, Development and Peace for the Twenty-first Century" and this special session reaffirmed the importance of gender-based approach. This session identified some focus areas with respect to gender and

[14] The reasons for the high rates of epidemic among young girls and women in Africa are attributed to women having much older partners who are more likely to be HIV positive, gender inequalities, sexual violence and conflict situations. The rise in the number of women contracting HIV indicates that gender inequalities undoubtedly fuel the epidemic (Gender and HIV/AIDS, 2005).

[15] Perspective is defined as the choice of a reference which allows us to sense, categorize, measure or codify experience. Utilizing a perspective involves utilizing a value system and its associated belief system and allows comparisons with one another (www.en.wikipedia.org/wiki/Perspective_(cognitive)). In this regard, when we adopt a gender perspective, we adopt an analytical point of view that takes unequal power dynamics between men and women into consideration.

[16] Many international meetings highlighted the importance of working towards reversing the epidemic and recognized the gender and human rights issues. These meetings involve the UN Commission on the Status of Women, the Millennium Summit, the special sessions of the UN General Assembly on ICPD +5, Beijing +5 and Social Summit +5 (UNDAW, 2000).

HIV/AIDS, including education, social services and health, sexual and reproductive health, violence against women and girls, poverty, vulnerability of women including exploitation and trafficking (UNDAW, 2000).

Five months after, in November 2000, an 'Expert Group Meeting' on 'HIV/AIDS and its Gender Implications' was organized by the UN Division for the Advancement of Women, Department of Economic and Social Affairs, in collaboration with the World Health Organization and UNAIDS. During this expert group meeting, it was recognized that HIV/AIDS had become a major challenge to gender equality and the advancement of women. It was reported that the cultural, social, economic and human rights dimensions of the pandemic could be seen more clearly by recognizing the interaction between gender and HIV/AIDS. The experts stressed that the vulnerability of the girls' was not just due to their physiology, but also due to their relative lack of power over their bodies and sexual lives, which were reinforced by the social and economic inequality. They also identified that women and girls are blamed more than men for HIV/AIDS; they are under more risk of contracting HIV and take more burden for providing care and support to their family members (UNDAW, 2000).[17] 'Women and HIV/AIDS' became a priority theme for the CSW's work and a special meeting was organized in March 2001 for discussing the vulnerability of women and the girl child to HIV/AIDS (UNCSW, 2001).

The outputs of these meetings undoubtedly contributed into the UNGASS Declaration adopted by 189 nations in 2001.[18] The UNGASS Declaration, the

[17] The experts articulated key issues and concerns including sex, gender and sexuality, stigma and discrimination, right to information and education, right to access to prevention, treatment and health services, the effect of religion and poverty, and lack of economic security and rights, being exposed to violence and having vulnerabilities due to war and conflict situations. The experts provided recommendations which included immediate actions, such as economic empowerment of women, gender sensitive prevention, working with men, ensuring the rights of women and girls during the peacekeeping operations, war and conflict, as well as specific recommendations to international institutions. They recognized that their recommendations would be valid only if there are political commitment, adequate resources, good governance and democratic participation (UNDAW, 2000).

[18] And also to the Millennium Development Goals which involved HIV/AIDS and gender. These goals are as follows: 1. Eradicate extreme poverty and hunger, 2. Achieve universal primary education, 3. Promote gender equality and empower women, 4. Reduce child mortality, 5. Improve maternal health, 6. Combat HIV/AIDS, malaria and other diseases, 7. Ensure environmental sustainability, 8. Develop a global partnership for development (http://www.un.org/millenniumgoals/goals.html).

declaration of the United Nations General Assembly special session on HIV/AIDS, clearly stated that dealing with human rights, gender inequality, poverty, stigma, discrimination and denial was essential in the response to HIV and AIDS (UNGASS, 2001).[19] It is now accepted that HIV is a developmental, security and human rights issue, and gender is an important factor for its implications and impact (Ertürk, 2005).

Many authors have discussed the role of gender in accelerating the epidemic due to (i) the differential and societal roles assigned to men and women, women often have no control over their sexuality, (ii) the obligation to follow certain social practices such as early and forced marriages, female genital mutilation and other forms of violence against women (Cohen, 1992 and 1998; Cohen and Reid, 1996; UN Films, 2005; Ertürk, 2005, Gender and HIV/AIDS, 2005) and pointed out that women are subject to punitive laws and unequal treatment by the community and do not have equality in power and decision making (Aggleton et al, 1999).[20]

Parallel findings were reported from many countries in 2006. For example, (i) in Botswana, women's vulnerability to HIV infection was found to be increased by the low economic status and inequitable gender relations which stopped them from decision-making in sexual matters; (ii) In Lesotho, due to the legal classification of women as minors, women were found to be lacking the means to protect themselves from HIV; (iii) In Pakistan, gender discrimination was identified to stop the access to prevention and health services; (iv) in Bangladesh, improved access to sexual and reproductive health interventions was assessed as a need; (v) In Albania, developing clear policies to address the needs of women and young girls was found necessary

[19] Following the UNGASS Declaration, a specific fund, "The Global Fund to Fight AIDS, Tuberculosis, and Malaria", was generated to fight against the world's pandemics, and funds raised became a UNGASS indicator to measure the commitments of the world made in 2001. In 2006, over 8 billion dollars was made available to fight against HIV/AIDS (UNAIDS statistics, 2007). Many countries, including Turkey have benefited from the Global Fund to implement projects against AIDS UN Theme Group on HIV/AIDS facilitated the process for bringing the Global Fund to Turkey and the country started its 2 year prevention program with the Global Fund Grant ($US 4 Million) in 2005. Civil Society Organizations have been implementing projects focused on vulnerable populations including people living with HIV, injecting drug users, males who have sex with males and sex workers.

[20] Aggleton et al (1999) also pointed out that woman's cultural, economical and social disadvantaged position constraints women's equal access to treatment, financial support and education.

(UNAIDS, 2006).[21] The feminization of the epidemic has been found to be parallel with the level of development, poverty, and the status of women in many countries. UNAIDS points out the need to continue and increase the attention for women and girls (Piot, 2006).

The vulnerability of women and girls' to HIV/AIDS was reported by the UN Special Rapporteur on Violence against Women (Ertürk, 2004 and 2005); women face violence both by intimate partners and by strangers, not having control over their own sexuality, and they may become victims of organized violence or trafficking and at refugee settings. Poverty and illiteracy, conflict situations (e.g., vulnerability to rape due to not being protected by family and community), genital mutilation and other harmful practices (e.g., forced labour, sexual slavery), prostitution and early marriages make women vulnerable to the epidemic. Ertürk (2005) discusses the gender dimensions of HIV/AIDS in her report to the UN Commission on Human Rights and stresses the intersectionality of violence against women and HIV/AIDS.

All these discussions, reports and research demonstrate that AIDS is not just a health issue; HIV/AIDS is a multifaceted and gender has a great impact on it, and it brings out many issues into the daylight, such as power relations, taboos on sexuality, and unequal treatment. Before discussing these issues in more detail, I now would like to present a similar case in history, the case of syphilis, to demonstrate that power relations and our responses to sexuality have not actually changed very much in the last five hundred years. After then, I will discuss about the gender and embedded power relations within the society's patriarchal structures affecting HIV-related stigma and discrimination.

[21] The recommendations in the report included supporting the programmes that address gender inequalities, reforming legislation including the ones on harmful traditional practices, domestic violence, property and inheritance rights of women and girls (UNAIDS UA Report, 2006).

2.3. Syphilis: A Similar Case in History

Syphilis appeared as a sexually transmitted disease and an epidemic at the end of fifteenth century in Europe (Davenport-Hines, 1990).[22] Just like the response towards AIDS, syphilis received a very similar negative response from society at the time.

The ones who contracted syphilis were excluded, discriminated and stigmatized. People contracting syphilis were seen as sinners, evils in the society and treated in inhumane ways to be punished. As in the case of AIDS, in 1910s in the UK, significant discrimination was seen towards women who worked as prostitutes or towards men who passed the disease to innocent women and children. Even though there was a strong reaction towards "the guilty", there was also sympathy towards "innocent" patients, such as a girl who could have innocently contracted syphilis through her parents or a wet nurse (Davenport-Hines, 1990: 30).[23] This is very similar to the findings of research on how HIV positive women who had engaged in sexual behaviors out-of-wedlock were perceived more "guilty" than the married women who had contracted HIV (ICRW, 2005). These demonstrate how stigma and discrimination are used as mechanisms to control unwanted behaviors.

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[22] Syphilis badly hit Spain and Italy in 1495, and then spread to France, Germany, the Netherlands and Greece in 1495, to the UK in 1497 and to Russia and Hungary by 1499. It was seen in India in 1498 and in China in 1505. Beside its medical aspect, syphilis created a strong stigma and discrimination in societies. Syphilitic patients were isolated, excluded, blamed as "sinners" and left for death. The origin of syphilis was attributed to originate from "others" by various groups, nations. For example, the French called the disease "Italian or Neopolitan", the English called it "French pox", Polish called it "German" and Persians called it "Turkish" (Davenport-Hines, 1990).

[23] As in the case of AIDS, the members of society tried to ignore the problem, excluded the ones who did not follow the rules of the society, and behaved in a way that "regular people should not need information on syphilis" and promoted control of sexuality. For example, the responses of the decision makers to syphilis included (1) providing inadequate care and effort, (2) seeing public education as unnecessary, (3) banning the use of the word "syphilis" from language, (4) excluding venereal diseases from the medical school curriculum, (5) avoiding the distribution of condoms and (6) promoting the idea that people with promiscuous behaviors may as well die from their own sins and ignorance instead of having the freedom of sex and not worrying about the sexually transmitted diseases; Examples include: (i) the cure for syphilis was discovered in 1910 which was awarded by the Nobel Prize caused big conflict reasoning that the scientist was responsible for "removing the punitive element from fornication (p. 195), (ii) the earliest parliamentary reference to condoms dates back to 1705 in England where the use of condoms were seen as sinful since they led to freedom of sex. The condoms would not only avoid women getting pregnant but it would also hide the "sinners" in the sense that the risk of transmitting sexually transmitted diseases would be reduced. The cost of condoms was quite high in the early eighteenth century and only a few could afford using them (Davenport-Hines, 1990).

Just like in the case of AIDS, unequal power relationships also shaped judging "women" for contracting or for transmitting syphilis. Medical settings became an environment for exercising authority and reflecting the power structures in society (Davenport-Hines, 1990)[24]. For example, in one hospital in London, unmarried women with sexually transmitted diseases were rejected, although there was not such rule for bachelors (Davenport-Hines, 1990: 187).[25] Blaming syphilis as "feminine evil" was one of the reactions during the French invasion of Italy in 1495 where it was believed that women took revenge by spreading the disease to the soldiers (Davenport-Hines, 1990: 45).[26] This thought seems to be still common for blaming women as the seeds of disease in the case of spreading HIV (PANOS, 2001), indicating that men who get engaged in sexual relationships are innocent. This is also noteworthy to see how norms have not changed for women in the last 500 years and how women's subordinate position has been sustained. Therefore, the society builds the norms and values and these become tools for stigmatizing and discriminating, groups with deviant and inappropriate behaviors are marginalized and excluded, and severely punished, such as not giving them any care and support.[27] This exercise of power can be seen towards already oppressed populations, such as

[24] In the 17th century two special care centers in the UK opened for syphilis which had the punishing inscription as "significant of sin and sorrow" on a sundial relevant to these centers. The moral aspect of syphilis appeared more of a concern among the health care personnel. The treatment for syphilis became a way of ridiculing and embarrassing people who showed deviant behaviors, and this was mostly seen at the medical settings where a doctor has the authority and the power over the patient. Some patients were given lectures and embarrassed among the other patients besides having treatments, thus some preferred not to have the treatment and die in their own misery.

[25] In 1916 in the UK, 10 % of the urban population was found to have syphilis. Yet, the medical schools did not include venereology into the medical curriculum and the subject could be only studied as a post graduate study (Hall, 1991).

[26] Most people believe that women working in the sex industry are the sources of HIV/AIDS and do not quite consider that the risk comes from clients (NSP, 1997). Jeffreys (1997) discusses that even though men are a strong part of the prostitution, they are excluded from the picture and not stigmatized for having sex with women.

[27] When Center for Disease Control in the US identified a second route of transmission, blood transfusion, and called the urgent attention of Blood Banks to stop the transmission of HIV through this route, there was reluctance in the response since AIDS already had a stigma attached to it; by the time the Government acted to stop the transmission of HIV through blood transfusion, 35,000 hemophiliacs (50 % of all hemophiliacs) already had the virus and waiting for death since there was no medication at the time. Similarly, later responses to AIDS treatment were delayed by not reducing the cost of the medication. This lasted until 1000 people living with HIV united to protest the current medication policy by demanding the Government to provide an access to medication so that they could live not sentenced to death. Currently, only 5% of PLHIV can have an access to medication and most live in the developed countries (Frontline, 2006).

women who do not follow the societal norms. Making associations between people and inappropriate behaviors, as will be discussed in the following chapter, is part of the stigmatization process; and developing different responses, such as excluding them, explains discrimination.

Stigma and discrimination are important concepts within the context of control mechanisms in societies. The next chapter discusses sexuality, gender and patriarchy prior to discussions on the manifestations of HIV-related stigma and discrimination.

CHAPTER 3

NORMALITY AND CONTROL

3.1. Stigma and Discrimination

Stigmatization and discrimination seem to be part of a complex process that involves identifying differences, devaluing some attributes, creating categories based on the identified differences, using devalued attributes as oppressing agents and exerting power over the others. Therefore, it may be beneficial to examine the process of how differences among humans are utilized to create divisions in societies.

The basic differences among humans in the world are based on sex, age and race. If it was an ideal world, these differences would carry no value and would not form the basis of conflict; it would be very peaceful to live all together by accepting all our differences. Sex, race, religion and sexual orientation are used by societies to categorize and divide people (Tzedek, 2000; Goffman, 1963) and also each category is further divided into sub-categories (Lorde, 1984).

Lorde (1984) explains how the division process occurs in societies: Before giving a response to a difference, there has to be a constructed value attached to this difference in a society. In other words, members of the society construct their own values for valuing or devaluing a difference, and give positive or negative attributes to the differences or to the group of people who are identified to be associated with these differences. These differences may induce various responses in people such as (i) ignoring the difference, (ii) copying it (if people believe it is a beneficial attribute), or (iii) destroying the difference (if they believe it is a negative attribute)

(Lorde, 1984). Therefore, differences, if valued, are likely to be copied, reproduced and produced in societies.

However, as the members of a society give negative values to some attributes (e.g., particular race), those attributes then become stigma to discredit a person or members of a group in the eyes of others (Goffman, 1963). Stigma is defined as a "mark or sign of disgrace or discredit"; people who are identified with negative characteristics, are perceived as less worthy than others or not deserving respect (Gilmore and Somerville, 1994: 1340). It can be defined as a "mark of shame" that plays a role in the psychological and social relations (Herek and Glunt, 1988: 886).

Humans are social creatures and they survive better with their support structures within a society. If one is excluded from the network of any support structures due to the pressure exerted by the society, then the meaning of life becomes lessened, the surrounding environment gets narrower, giving very little chance to sustain one's successful existence in the same society. Thus, stigma and discrimination become tools of control and means of power.

To stigmatize people, "stigma symbols" are identified by the members of the society (e.g. skin color) and Goffman (1963) summarizes that a person can be stigmatized based on three characteristics: 1) *physical deformity*, for example a mark on a person's skin, such as the loss of a nose, 2) *individual characteristics* that indicate an immoral behavior, such as homosexuality,[28] 3) *tribal characteristics*, such as ethnicity, race or religion. However, sometimes, there may be no identifiable symbols, such as in the case of people living with HIV. In other words, people living with HIV look the same as any other members of the society that no one can recognize them. In such a case, negative attributes can be established by associating HIV positive people with stigmatized and marginalized groups, such as women in the

[28] With respect to discrimination related to an immoral behavior, researchers explored if there is a correlation between the negative responses to homosexuality and cancer and if this would create the same stigmatic response, since it carries similar characteristics with AIDS. As expected, AIDS was found to create more stigmatizing responses than cancer and that negative attitudes toward homosexuality was related to negative attitudes towards AIDS but not people living with cancer (Greene and Banerjee, 2006).

sex sector, drug users, homosexuals, etc, thereby categorically linking all marginalized populations with HIV positive status.

If there are no stigma symbols, it is hard to stigmatize and discriminate. Some examples of how the society creates its stigma symbols and how the members of the society try to avoid being stigmatized are as follows:

- In some cultures where breastfeeding is common, "not breastfeeding" may be become a stigma symbol due to the nature of HIV transmission through breastfeeding. In this case, HIV positive women may continue to breastfeed to avoid being stigmatized and discriminated (ACORD, 2004). Some commonly used terms, such as "mother-to-child transmission, brings even more stigma to women and it is suggested that this term should be changed to Parent-to-Child transmission (PANOS, 2001).
- Similarly, in some cultures, "not bearing children" can be associated with "incomplete womanhood" in India. In this case, HIV negative women who are married to HIV positive men may feel pressured to get pregnant from their husbands, even though they know that they can contract HIV through getting pregnant but may choose to do so in any case (Gates Foundation, 2002).
- In 1980s, there was a radical demand of W.F. Buckly in 1980s that all individuals living with HIV must be tattooed to so that they can be identified (AVERT, 2007).[29]

The stigmatization process then requires identifiable differences and the society's given value to these differences in order to discriminate "others". People use stigmas to create a division in societies as "us" versus "them", and this can be a way of creating homogenous community following similar and desired values; thus stigma and discrimination can be tools for exerting control in the society, such as for

[29] One interesting example can also be given from history how a "stigma symbol" can be attached to women who are already stigmatized as "prostitutes". These women probably looked no different than the "other" women. With a research in 1800s, it was declared that women in prostitution had anomalies in their skull development, saddle shaped palates, lack of cranial symmetry, depression at the root of nasal bone and tendency of eyebrows to meet (cf. Joarder, 1983). In this case, these attributes become stigma symbols and thus unwanted characteristics for women.

marginalizing some groups, making them into "the others" and excluding them (Gilmore and Somerville, 1994).[30] Society then protects the norms and values as well as life, health, and property; people who stigmatize then feel superior, benefit from the resources in the society (Gilmore and Somerville, 1994). This may also explain how valued attributes can be used within the patriarchal structure by women to oppress other women who do not have these attributes. For example, chastity becomes a valued attribute, thus women who do hold their virtue oppress the "others" who did not hold their virtue. In the case of contracting HIV, if a woman is assumed to have engaged in immoral behaviors, she is then discriminated by other women.

Stigma and discrimination then can be linked to unequal power relations and domination in the societal structure. Power is known to be the source of many struggles with respect to sexism, racism, etc. in societies. The attributes of people such as race or sexual orientation can be used by dominating powers to create unequal relationships; stigma which leads to discrimination becomes a means of exercising power; it is utilized as a tool to produce, justify, and also perpetuate power over the stigmatized (Aggleton and Parker, 2003; Parker et al, 2002). Researchers discuss that the values that are owned by the dominating powers are more valued, and the values of the stigmatized are devalued, resulting in the stigmatized population being discredited and pushed down even further (Aggleton and Parker, 2003). Research therefore has found links between pre-existing sources of stigma and discrimination, such as sexual relations and divisions, gender relations and divisions, etc. (Parker et al, 2002) (see Appendix A2). This also provides an explanation why women may be more stigmatized than men in societies. Women, being the subordinates, have attributes that are already devalued, and they are pushed down even further if they contract HIV.

Alonzo and Reynolds (1995) also discuss that stigma is a multidimensional concept developed around the issue of deviance; and that stigmas create a border between

[30] Lorde (1984) points out that each of the attributes of a valued category sets a foundation for oppressing the "other" who is not the members of this valued group. Lorde says, "*differences don't separate, but our reluctance to recognize differences seperates*".

"normal" and "abnormal".[31] This is to say then that valued attributes become normal, and devalued attributes become "abnormal", therefore, "normality" is created by dominant powers in the society and this normality is reinforced. Normalizing values, stigmatizing and discriminating are all related with power issues in societies.

As gender is socially constructed, gender roles are also normalized, accepted, and reproduced in societies to keep subordinates in place. Sexuality is also normalized within gender construction. For example, male and female promiscuity are perceived differently, and while men are valued as "playboys" for being promiscuous, women are devalued for displaying the same kind of behavior. How then are these values normalized? How are the sexual behaviors categorized and accepted by the members of the societies? The next section will discuss the "normalization" process for sexuality, which will then be followed by discussions on gender and the patriarchal power structures behind it.

3.2. Sexuality and Normality

"Power is the invisible architecture of the social."

Westwood (2002: 6)

The quote from Westwood indicates that the power structures in society shape our lives, perceptions and the social structure we live in, without us even realizing it. We are introduced to the negative or positive norms that already exist, or will be constructed by the dominant powers in societies, and we accept these norms. The society sets the rules around these norms and keeps the societal structure in place. Normalized sexuality (i.e., why sexuality is normalized the way it is now) exists within the gender construction underneath the power structure of patriarchy.

Normalization involves the process of producing standards by which people can be judged to be normal or not.[32] The desired standards are accepted and legitimized and

[31] Ann Cudd (2006) describes "normal behavior" as the behavior is normative, expected and accepted in the culture.

[32] The concept of being a "normal human" appeared in 1800s in medicine where normality was associated with being healthy (Adams, 1997; Goffman, 1963). This medical term moved from the medical to sociological and political fields (Adams, 1997).

others are not accepted and left out. Normalization can be used as an effective practice of power both at individual and societal levels; it regulates the social norms, defines and limits the number of choices available to the members of the society (Adams, 1997).

As one group comes into power, the norms also change in a society. For example, when Europeans colonized North America, they already had their constructed norms and beliefs with respect to sexuality. They observed that the Native Americans displayed unacceptable sexual behaviors, such as practicing polygamy or not connecting sexuality with sin. Premarital sex was normal in the local indigenous culture and marriages occurred after the birth of a child--whereas premarital sex wasn't accepted in the English culture.[33] These behaviors were conflicting with the beliefs of the Europeans, so they tried to change all these norms for the Native Americans who were converted to Christianity (D'Emilio et Freedman, 1997).[34]

In other words, the norms of a dominant group were introduced to the subordinate group as "being normal" and the others "being deviant". Similarly, the concept of middle class moral superiority was developed in the nineteenth century upon observing the working class sexual behavior (D'Emilio and Freedman, 1997); it was seen that families who had to live in one room engaged in sexual behaviors and

[33] It should be noted that normalizing sexuality within wedlock may apply strongly to women, otherwise prostitution would not exist. For example, with the rise of the prevalence of syphilis and gonorrhea, which are sexually transmitted diseases and were lethal at the time, countries, such as America and the UK, normalized prostitution, regulated sexuality and developed contagious disease acts (Hall, 1991). Another example is that, during the 1874 Civil War at Missouri State in the USA, prostitution was legalized and medical authorities inspected the women to ensure that they are "free of diseases". Upon monitored once a week, women were given certificates for being clean. To consider the health of the soldiers during war, women were transferred to Cincinnati to serve men as a group of prostitutes (D'Emilio et Freedman, 1997).

[34] Regulating sexuality depends on dominant powers in society and sexual norms may change in societies over time. For example, homosexuality was penalized in Britain (under the Buggery Act) in 1533 which allowed the punishment and death penalty until the year 1861 (http://en.wikipedia.org). The existing power dynamics can bring the need to hide away from their families, colleagues in the fear of being identified and discriminated as the outsiders in the society (Parks, 2004). For example, during the time of Churchill, police would look for homosexuals and degrade their humanity; the homosexuals were judged and penalized for attempting sodomy (Davenport-Hines, 1990: 130). The norms may change in societies, though, as legalization of homosexuality occurred in 1967 in England (http://en.wikipedia.org). With the use of birth-control tools and devices, sexual liberation and individual happiness became the focus of sexuality. The idea of sex only for procreation evolved into personal identity and pleasure in sexuality (D'Emilio and Freedman, 1997; Davenport-Hines, 1990). Thus, the norms on sexuality changed.

women gave birth in the presence of the whole family, including children and senior members of the family. Based on the perception that the sexual behavior of working class was promiscuous and unacceptable, the dominant class in the 18th century in England created the morality values for sexuality, privacy of the couple, of the nuclear family, of the individual and new taboos for privatized bodily functions, including sexuality (Barret- Ducrocq, 1991). One other example from history is that, sexuality outside the marriage was seen as dirty or unclean, and people who had premarital sex were punished by whipping and fines (e.g., in Maryland in America) (D'Emilio and Freedman, 1997).[35]

In these examples given, the sexual norms were used to regulate, change and control. Controlling sexuality has become a tool of power and various sexual behaviors have been normalized in many parts of the world throughout history.[36]

As research demonstrates, control of sexuality is especially true for women in many parts of the world (e.g., ACORD, 2004; Ertürk, 2004; UNAIDS, 2000). The tools for controlling women's sexuality involve the association of virginity of girls with family honor, murdering of girls and women in the name of family honor, rejecting promiscuous women and excluding them from the society, female genital mutilation, and regularized reproductive health-services (e.g., abortion as a legal issue).

Despite the fact that woman's control over her own sexuality is human rights, discussions on women's sexuality took place at many high level United Nations meetings where representatives from the member states strongly argued and negotiated on this issue while forming policies within the frame of women's human

[35] The rise in syphilis indicated the failure in control of sexual behaviors. The appearance of venereal diseases in history and its associated fear has been used to control sexual behaviors and blame people for their sexuality and desire (Davenport-Hines, 1990). In 1920s in Europe, monogamy for men started to be promoted and eroticism started to be integrated into marriage and thus attitudes towards sex within "normal heterosexuality" changed (Hall, 1991).

[36] Sexuality has been associated with a range of human activities and values including reproduction, pleasure, recreation and power (D'Emilio and Freedman, 1997). The definition of sexuality has been medical, religious, romantic or commercial and the different views have gained weight at times based on the nature of the economy, the family and politics (D'Emilio and Freedman, 1997). It has appeared as an important source of political struggle and the power it brings may involve legislation for regulating sexualities (Westwood, 2002).

rights. Violent practices against women for controlling women's sexuality, such as child marriages and female genital mutilation, have been attributed to the "culture" of some countries, indicating that nations of the world should not interfere with these violent practices. However, attributing violent practices to "their" culture makes this issue to be seen as the problem of "others" which (1) delinks violence against women from gender; (2) can lead to racism by categorically condemning a cultural group; (3) overlooks material basis of cultural practices; (4) normalizes violence against women in one's own culture. Violence against women exists across all cultures and religions around the world, including in the developed world, appearing in various forms and practices (Ertürk, 2007).

Therefore, the control over women's sexuality, which can involve violent practices against women, is universal and institutionalized, as can be demostrated with the discussions taken place at many high level meetings. Why is it important to control women's sexuality? Ertürk (2004) explains that the male power becomes a tool for controlling women's reproductive capacity and sexuality within an institutionalized social mechanism. Women, as she explains, become a means of demonstrating male power, both in private and public space, for example, rape is used as a weapon of war during conflict situations to violate the cultural boundaries of the enemy.

The hidden cause of the problem is that patriarchal norms are built into the institutions of societies to sustain women's subordinate position (Ertürk, 2007). Patriarchy is the power behind constructing gender, sexuality, and normality in societies. Before looking at patriarchy, its relation to gender and how it is reproduced and sustained universally, I would like to end this section with Fatima Mernissi's (2000) words: *"It is not by subjugating nature or by conquering mountains and rivers that a man secures his status, but by controlling the movements of women related to him by blood or by marriage, and by forbidding them any contact with male strangers."* (Mernissi, 2000: 203)

3.3. Patriarchy and Gender

In *The Distinctive Feature of Patriarchy* (1998), Berktay discusses that patriarchal system has brought more and more power in the society and has adopted means such

as gender and religion[37] to perpetuate more power. As the states became more stratified, the patriarchal family system, which involved foundational rules, such as passing inheritance from father to son, controlling women's sexuality by men, became more and more institutionalized, and women's sexuality became first the father's and then the husband's property, and woman's sexual purity became a virtue. Examples can demonstrate how even thousands of years ago the societal rules and laws based on patriarchal system were quite oppressive for women, these include (i) allowing a man to break the front tooth of a woman (with a baked brick) upon her disobedience (3000 BC), (ii) giving the right to men to arrange marriages for his children, (iii) allowing man to pawn his wife and children for his debts or letting his wife and children be punished in his place. Assyrian law recognized rape of a virgin as an invasion of father's property and economic rights. Also, adultery was a given right to men whereas women were punished by death (Berktay, 1998). Berktay's article shows women's subordinate position within the context of the association between state, family and the household. Ertürk (2004a) points out that even though women's participation in the labour market reduced the divisions between the public and private spheres, patriarchy still has not dissappeared.

Attention was raised to women's oppression after the slavery movement and to the patriarchal power. During 1960s and 1970s, modernist feminists argued that power and oppression were the universal truth which can reveal key mechanisms in all societies. Power, they believed, involved two key components: "suppression and dominance". The feminists explained that power, which is an attribute or a property, is possessed by the dominant group in society. They adopted the term "patriarchy" during that time to define the social and negative nature of this power (Beasley, 2005).

In the early days, Engels (1884) referred to patriarchy as a form of the family in which the power is held by the paternal head (cf. Murray, 1995). Over the years, the systematic characteristic of patriarchy has been realized, and now patriarchy is defined as a system where males are dominant over females (Bishop, 2002). Some

[37] The institutionalization of monotheistic religions, as she describes, has become the power of the ruling class, reinforcing the existing inequalities, and creating more power over the years.

feminists see patriarchy as "systemic and trans-historical male domination over women"; men and women, being two groups in society, have had unequal power relations and men being the dominant group, have had systemic power over women (Beasley, 2005: 254).

Walby (1986) defines patriarchy as a theoretical concept in which she describes capitalism and patriarchy being relatively autonomous and yet interactive systems.[38] Walby (1986) argues that patriarchy is systems of interrelated social structures and that within these social structures men exploit women. She discusses that gender relations can be explained at the level of a social system. Within this context, Walby analyzes various forms of patriarchal and capitalist relations. For example, the division of labour in the household contributes both to the patriarchal and capitalist modes of production such that domestic work becomes a direct value to the patriarchal mode of production, woman's domestic work sustains the patriarchal family system and she reproduces the family through her reproductive capacity; and her added value turns into capital through her husband, which is an indirect value to the capitalist mode of production, where the husband independently works and adds surplus within the capitalist system. Walby then examines patriarchal relations in paid work, discusses their necessity to sustain the existing system (these include control of women's access to paid work, non-admittance of women to some universities, etc.). She sees the state as a patriarchal site, but also capitalist, where the state upholds the oppression of women by various means, such as blocking their political involvement, or supporting their household position. She also looks at violence against women within the patriarchal structure, where it exists universally and institutionalized systematically. Walby sees some of the patriarchal relations, such as the relations in sexuality, as the necessary conditions of patriarchy to sustain its existence. She argues that some certain forms of sexuality, particularly institutionalization of heterosexuality, are fundamental to sustain patriarchy because it keeps the mode of patriarchal production in place.

[38] She bases her definition to 'dual-system theory' of patriarchy where patriarchy and capitalism are seen as independent from each other.

Besides male domination over women, patriarchal structure allows construction and sustaining hierarchical relationships in which power is exercised within the same sex category based on other differences such as race, ethnicity. Millet defines patriarchy as domination of males over females, as well as of old males over young males, discussing patriarchal power as sex and age specific (cf. Murray, 1995). Hartmann states that men are able to dominate women through the hierarchical social relations established between men (cf. Murray, 1995). Ertürk (2004a:7) argues that "patriarchy is the definition of "manhood": the breadwinner or provider (i.e. class relations) and regulator of women's sexuality, whether in the form of protector of honour or as transgressor of women's body (i.e. gender relations)". She says:

> Gender inequality is rooted in patriarchal ideology and institutions that entail relations of domination not only between women and men but also among men themselves. Historically, some men have used power, whether overtly – as in slave society – or more discretely – as in modern times – to control the labour of other men, which is often referred to as class relations. Gender relations are the most pervasive and universal of all forms of inequality which cuts across class, ethnic, racial and national lines.
>
> (UNDAW, 2000: 2)

Thus, patriarchy is a system that is reproducible, trans-historical, universal, sex and age specific and utilizes various means to sustain its existence; gender being the most commonly used that cross-cuts other distinctions in societies.

Gender relations can be seen as a consequence of patriarchy (Walby, 1986). Beasley (2005) discusses that gender is an enactment of power and that both woman and man function as an effect of power. It may be then useful to examine gender to understand its relation to patriarchy.

A sex category is turned into a gender status as the person is named, dressed, and receives other gender markers (Lorber, 1994). While sex is a biological determination through birth, gender is an achieved and learned management of normative attitudes and activities that are appropriate for each sex category. Gender is not a set of traits, or a variable or a role but it is the product of social acts or doings

and it is an "outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society" (West and Zimmerman, 1991: 14). Gender is socially constructed: it involves rather a complex process which includes psychological, social, cultural interactions; individuals find themselves expressing their gender and perceiving the behaviors of others in the same manner. Constructing gender includes creating differences between girls and boys or men and women that are not biological or natural (West and Zimmerman, 1991).

Gender then involves learning the norms and rules in societies and acting accordingly. Members of each gender get involved in self-regulation as they start monitoring their own behaviors and those of others, and form "gender identities" that are important to individuals to maintain in the society they live in (West and Zimmerman, 1991). Therefore, we have gender instructions to learn and follow in life, put them in action without realizing and manage and sustain our "gender" identities. If people do not assume the roles, or interact in the way that they are supposed to, then these people are perceived as "deviant", discriminated and excluded from the society.[39] West and Zimmerman (1991) discuss that the allocation of power and resources exist in domestic, economic, political domains as well as interpersonal relations. The biological differences between men and women are turned into "natural" differences in daily life and reinforce the hierarchical arrangements between each sex, placing men above women. Thus, these created "natural" differences based on sex category are sustained.

3.4. Sustenance of Gender Constructs through Sexual Norms

Sexual norms form an important part of gender identity construction. It may be useful to look at how some attributes are claimed as normal by authorities so that they are accepted by the members of the society without questioning. The European

[39] What then if one fails to follow his or her gender in societies? Interviewing a transvestite from "Pink Life Association", a transgender association in Turkey, showed that people are obliged to fulfill their gender identities combined with their biological sexes if they want to be members of the society. She, with her gender, and he with his biological sex, finds it impossible to work at a regular job since the job places are all gendered based on sex. She finds it very difficult to access to education or health services. She, as she expresses, is excluded by the society, ignored by authorities and sometimes faces violence on streets by men who follow their biological sex and matching gender identities.

and North American sexologists in the late 1800s listed some strange and unusual sexual behaviors (Adams, 1997).[40] The following examples listed by Davenport-Hines (1990) demonstrate how sexual norms contribute to the construction of gender and how men and women are placed in a hierarchical structure in society:

1. In second century AD, philosophers stated that men were the fetuses which had grown to their full potential whereas women were the failed fetuses and thus "were lower in the natural hierarchy"; it was also interpreted that "the Creator had purposely made one half of the whole race imperfect, and, as it were, mutilated" (p, 9),
2. "Women were natural 'abstainers' … 'passion' was not 'as strong in women as in men'" (p. 198),
3. In 1899, many people believed that venereal disease would disappear if it was transmitted to a completely innocent person (p.201) --this myth still exists in most parts of Africa and many young girls are raped by HIV positive men,
4. A pretty English girl was made to be loved otherwise there was no reason for her to be pretty (p.205),
5. Children born to unmarried women at the special hospitals that accepted syphilitic patients were rejected from baptism since they were 'born in sin' (p.253),
6. In 1940s, there was a perception that the unmarried women who engaged in sexual intercourse for enjoyment were to be seen or treated as 'amateur prostitutes' (p. 265),

[40] Normalized sexuality has involved heterosexuality in western cultures. For example, in 1868, homosexuality was defined as men being feminine and women being masculine in their behaviors. Later, homosexuality was identified as a psychopathic and an "abnormal behavior". Meanwhile, homosexual men were identified based on their incapability of fitting into the clearly defined, normative gender roles but not based on the sex of the partners they were with (in other words masculine men who had male partners were not perceived abnormal). Heterosexuality appears as one of the norms in the society that is constructed as a desirable characteristic and reinforced through various channels starting from childhood. Strengthened by patriarchy, heterosexuality becomes a privilege and exerts power upon those who do not follow this norm (Adams, 1997). Adams (1997) in her book "The Trouble with Normal" explores the construction of sexual normality and how the new generations play roles that produce and reproduce sexual norms. Appropriate, traditional morals were given within clear gender roles, either formally or informally. The heterosexuality isn't only means of organizing relationships between women and men, but also it becomes a way of "maturity" and allows people to make claims on normality (Adams, 1997).

7. In 1950s and 1960s, the common perception was that a woman's life could not be complete until wifehood and motherhood is experienced and that premarital intercourse was wrong for girls which were also confirmed by the psychiatrists that this would cause mental imbalance. The girl should enter into marriage clean, sweet and she should be precious to her husband (p. 277).
8. In 1970s, where sex started to be seen as recreational and not just for procreation, the advice to girls was that pre-marital sex was not only medically dangerous but also morally degrading and destructive for nations (p.279).

The above examples demonstrate how norms are created for the benefit of the dominant powers in the society and how gender is used to control women and their sexuality. Similarly, Bharat and Aggleton (1999) looked at the sexual norms in the Indian culture and how women's sexuality is perceived differently than that of men's. In India, where male superiority exists strongly, researchers observed that women's sexuality was controlled such that women had to be virgins at the time of the marriage and stay loyal to their husbands; whereas men had more freedom in sexuality and their sexual needs were justified by the culture. Women, as wives, had to prioritize their husband's sexual needs and ignore their own. If the husbands cheat on wives, the wives are held responsible for men's sexual lives and blamed for not fulfilling the sexual needs of their husbands (Bharat and Aggleton, 1999). Also research showed that men can have as many sexual partners as they want whereas women are judged as promiscuous if they have more than one partner (ACORD, 2004; UNAIDS, 2000).

The above examples indicate that the sexual norms are constructed based on the dominant powers in society to shape the behaviors and attitudes of the members of the society, and to control women's sexuality and oppress women. Summing up the arguments presented, gender is a normalized and learned division, reproduced within societies, sustained and becomes a means of power. I now would like to discuss gender in Turkey, and how normalized sexuality is a manifestation of power relations between women and men.

3.5. Gender and Normalized Sexuality in Turkey

Turkey is a country where normality carries an immense importance for the members of the society. The gender division can easily be observed in the society where the privileges are granted to men. During the gender identity construction, girls are taught to behave well, go through strict control at schools and home and are encouraged to follow the constructed "norms" and "behave appropriate and in a certain way". Within the context of conformity in the society, sexual lives of girls and women are strictly controlled. However, this case is the opposite for boys and men; boys are encouraged to enjoy their sexual freedom before marriage. Even though, legally speaking, adultery can be grounds for divorce both for men and women today, men's adultery is generally socially accepted and ignored in the society (e.g., if a man cheats on his wife, the woman is encouraged by family and friends to keep the family unit as a whole, and very few families fall apart) whereas women's adultery may be punished very severely by the family.

İlkkaracan and Seral (2000) discuss the gendered notions of sexuality in Turkey and the control exerted on women by providing examples of behavioral, educational, and negative associations with women's sexuality: (i) Young boys, as they describe, are encouraged to show their genital organs to family and neighbors (to be proud of) whereas young girls are shamed if they accidentally show their underwear while playing, (ii) There is no formal or informal education on "women and sexuality" and access to information, and if there is any, it is in the form of technical form within the reproductive health training. Therefore, women do not get a chance to learn about sexuality and are limited from sexual experiences whereas freedom in sexuality is for men. This shows unequal treatment in gender notions of sexuality and men's superiority in the culture.

Similarly, Marcus (1992) who observed the Turkish culture as an anthropologist found that men's superiority in the culture can be seen in various forms such as men receive better education, have freedom in their sexuality, and are aware of being superior and control of women. He identified that punishment for adultery in the shape of violence was for women. Another study in Turkey demonstrates how women perceive men's and women's adultery differently. İlkkaracan's study (1998)

conducted in the eastern part of Turkey showed that men's superiority is accepted by women: three quarters of the women said that they could not divorce their husbands if their husbands commit adultery-- even though they would want to do so. The same study also found that committing adultery for women is perceived as family honor and could be a reason for honor killings. Thus, the rules are established in a way that gendered notions are well accepted by subordinates. Both of these studies show that the unequal treatment of men and women is accepted and violence against women, the sub-ordinates, is normalized.

Demographic Health Survey (2003) in Turkey also demonstrated men's superiority in Turkey and normalization of men's power over women: 63% of women aged between 15 and 19 believe that husband's violence within marriage can be tolerated and 40% of women accept their husband's violence (cf. Coşan Eke, 2006). This again shows that men's superiority over women is accepted, domestic violence becomes means of demonstration of power of men over women, thereby women are forced to normalize this violence (if they do not, there is more violence), and violence continues.[41] Ertürk (2007) points out that the root cause of violence against women is due to the patriarchal norms built into institutions or societies to sustain women's subordinate position.

In Turkey, until early 2000, the legislation included many provisions that made women subordinates. These included the legality of virginity tests for girls upon suspicion of having sexual intercourse, expelling girls from education system upon "proof of unchastity"-which opened doors for virginity tests, reduction of criminal penalty towards the murder of a girl if "the murder was related with damaging the family honor", not recognizing "marital rape", asking the husband's permission prior to abortion if a woman was married, and not legitimizing the children born out of wedlock (Anıl et al, 2005). The common implementation of the legislation with respect to virginity tests was demonstrated in a study conducted among forensic physicians in Turkey in 1999. This study showed that 118 doctors in Turkey

[41] Normalization of violence towards women shows itself in Turkish sayings such as "*kızını dövmeyen dizini döver*" (if one doesn't beat his/her daughter, he/she beats his own knee) or "*kadının sırtından dayağı, karnından bebeği eksik etmeyeceksin*" (it is necessary to keep the woman pregnant, and beat her on the back).

conducted a total of 5091 virginity exams within 12 months; and almost half of the doctors conducted these tests for social reasons (Frank et al, 1999). The year is now 2007 and it seems that it will take a long time to change these well-established practices which have been strongly embedded into beliefs; virginity still carries an immense importance for girls, honor crime is still an unresolved issue and media regularly announces girls having been killed for damaging the family's honor.

As a summary, gender becomes means to "create natural divisions" between two of the sexes, to claim normality, to control sexuality and to exert power over the sub-ordinates, and sustain the power relations that already exist in societies. The gendered notions exist in every society, regardless of culture, religion and development level of the countries.

The purpose of examining HIV/AIDS and syphilis, stigma and discrimination, sexuality, patriarchy, gender and normality was to demonstrate how HIV-related stigma and discrimination towards women is affected by the patriarchal power structures. The next chapter will look at some examples of gender and HIV-related stigma and discrimination against women in the world.

CHAPTER 4

GENDER AND HIV-RELATED STIGMA AND DISCRIMINATION

4.1. Global Trends

> … we are all 'us'- including as a global community- and as such we are all living with AIDS, whether infected or affected by it. This requires us to create a new dividing line, one between the past and the future, which will be marked by the fact that instead of stigmatizing, scapegoating and discriminating against others who are affected by disease, we act in humane, caring and compassionate ways.
>
> (Gilmore and Somerville, 1994: 1339)

Gilmore and Somerville's call is ideal but has not been achieved to date. If it was an ideal world, the power structures would not be institutionalized; perhaps they would not even exist. The society would give equal chance of life to every single person, regardless of race, ethnicity, gender or sex. Human rights would be respected and their practice would be "normal". There would be no wars in the world to demonstrate power and dominance. However, in the real world, we can see that there is a systemic power structure, and dominant groups perpetuate power over the "others" through various means and tools, which also help reproduce and sustain their power.

The manifestation of power can be observed in various ways, one of them being HIV-related stigma and discrimination in which gender creates the environment for perpetuating power over the sub-ordinates. Studies conducted on HIV/AIDS gender norms, such as freedom in sexuality for men but not for women, are used against women with respect to HIV-related stigma and discrimination. For example, in Zambia, Tanzania, Ethiopia, Vietnam and India, men were taught to have the right to

be more adventurous, whereas women were expected to be faithful to their husbands and to have high moral standards (ICRW, 2005). A female community counselor from Vietnam said:

> To say frankly, if men are still young and they indulge in play and get [HIV] infected, that's the general story of society. If a girl gets this disease, no one would like to get close to her, because it is a problem of her conduct and her morality. It is not tolerated in females compared to males. (ICRW, 2005: 25)

Similarly, a man in Ethiopia said:

> If a man gets infected, it will be said, "He got infected accidentally." But if the woman gets infected, the gossip about her will be more exaggerated. People say she brought the disease by going out with different men. (ICRW, 2005: 25)

Also, in India, if men were found to be HIV positive, this situation was accepted by family and relatives at a better degree since 'seeing other women' was seen as a 'normal behavior' for men's nature in India; it was found that men were generally not questioned on how they contracted the virus (UNAIDS, 2000; Gates Foundation, 2002).

In many countries, where women are discriminated at a higher degree than men, the below chain of logic may provide an explanation: "*1) She has HIV→ 2) HIV is sexually transmitted→ 3) She must have had engaged in sex with men→ 4) She should have kept her virtue, she shouldn't have got engaged in sex, sexual behavior is not for women→ 5) Thus, she must be promiscuous and immoral → 6) She must have disobeyed the rules of the society."* Whereas, for a man, this chain of conclusions may be different: *"1) He has HIV→ 2) HIV is sexually transmitted→ 3) He must have engaged in sex → 4) He is a man, of course he would have engaged in sex→ 5) Unfortunate that he slept with promiscuous women → 6) He has HIV but it is not his fault."* If this is in a homosexual context, then the logical flow may change again due to additional discriminatory factors.

Woman being held responsible for carrying the family honor has also been shown in other studies. For example, a study in Burundi demonstrates that becoming pregnant for girls before getting married destroys the family honour, and women having more

than one partner are called promiscous and rejected by the society. The values with respect to goodness, beauty and respectibility are passed to generations through family and education system (ACORD, 2004). Similar findings were found in India: if a woman was found to be HIV positive out-of-wedlock, she was rejected by her own father for shaming the family (Bharat and Aggleton, 1999).

This may be also why married women were rejected by in-laws after it is found out that the sons have HIV. A 25 year old positive woman in Mumbai said: "my in-laws blame me for their son's death… they say, *"You also have AIDS. Stay happily wherever you are". I took great care of their son... But they always say 'You married him and our son got bedridden…"*(UNAIDS, 2000: 25).

It was also seen that after the death of a husband, young women don't receive social support, and widows lack legal protection of inheritance and property rights, and may be pushed into sex work (UNAIDS, 2000). For example a 40-year-old woman said*: "my in-laws do not have a good opinion of me. They say that my husband got this disease from me. I sometimes feel why should I live with the insult. It is better to die. But I am living for the sake of my children"* (UNAIDS, 2000: 25).

The support structures around women do not exist when their behaviors are associated with sexuality (i.e., contraction of HIV is an indicator). Five hundred years ago, women were blamed as "feminine evil" for spreading disease (Davenport-Hines, 1990) and today; women can be seen as the "seeds of disease". Example of an illustrative quote is as such: *"The majority of old men think that it is women who spread AIDS in families. Others think that to get AIDS one must have been promiscuous to others. It is (seen as) a curse on the family" (*UNAIDS, 2000: 28). Blaming the woman can be even stronger if mother transmits the virus to a baby boy in cultures, such as in India, where the male baby is valued more than the female baby (UNAIDS, 2000). Men's superiority, thus higher value given to men, shapes this manifestation. For example, in cultures where a boy is much more valued, the daughter in-law will be held responsible for not taking care of the "treasure" of the

family, and thus the woman failed, so she is rejected.[42]

The above examples demonstrate clearly the manifestation of patriarchal power structures in societies through gender. They also show that HIV-related stigma and discrimination becomes means of power over the subordinates, in this case women, in the society.[43] Therefore, it may not be surprising to see that women are blamed for bringing the virus home (ICRW, 2005; UNAIDS, 2000; Letamo, 2003), for passing the virus to her husband and children and not being able to care for the household, and not being faithful to their husbands (even though they have been), and are unlikely to receive the kind of support and care that male household members would receive (e.g., UNAIDS, 2000; ICRW, 2005; PANOS, 2001; Letamo, 2003, etc.).

Even though the patriarchal power is universal, the manifestations of this power may differ from one culture to another. For example, in the case of Turkey, I found that a married woman who is HIV positive is not blamed for bringing the virus home, in fact she is perceived "innocent". She is also sheltered by her family and friends upon finding out that she is HIV positive. Why would this be the case?

4.2. Examples from Turkey Leading to This Study

Before starting my study, I observed very different manifestations of HIV-related stigma and discrimination against various people living with HIV in the Turkish society. I shall provide some of the interesting examples as below:

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[42] Where a man's value is higher in a culture, woman's subordinate position is normalized. A young bride in the family is placed at the bottom of the patriarchal structure, where she is below a man, but also below her mother-in-law. For example a health-care worker says: "*When a young woman who is first-time pregnant is found to be HIV positive we call her mother-in-law. We explain the report to the mother-in-law and ask her to get the son also tested. These girls are newly married they are really dumb and don't understand anything, so mother-in-law is called* (UNAIDS, 2000: 25)

[43] Other common forms of discrimination exist as invasion of women's reproductive rights, such as sterilizing HIV positive women without their consent, or forcing them to have an abortion during pregnancy; stopping women's access to health care, such as not providing care and support or delaying, providing anti retroviral medication only during pregnancy, and in the case of a family living with HIV, provided support mostly to men and refusing women out of the family and social environment (APN+, 2004; UN Films).

Example 1: One of the people who provided information on the type of discrimination she faced is a woman who had been loyal to her husband and who had contracted HIV through her marital relationship. She has hardly experienced any discrimination from any health-care personnel, and received high-level of support from her employer, friends, family and relatives. At the beginning, she found her HIV positive status very difficult to accept but later she decided that it is quite important for her to continue her life and care for her child. She slowly revealed her status to people around her and she has been receiving support and sympathy from many.

Example 2: Discussions with an HIV positive girl who was virgin and who contracted the virus through an unknown source (possibly from medical treatments?) also showed that she has received a high level of support from health care personnel, friends and relatives. She, however, couldn't accept her positive status, went through a deep depression and refused treatment for a long period of time. She found it very difficult to reveal her status to others. She later met an HIV positive man who fell in love with her. Her family accepted the HIV positive man very easily, without any discrimination. They got married and moved away to a different city to start a life together and prefer not to reveal their status to anybody.

Example 3: Anecdotes of an HIV positive woman who is divorced revealed that she faced unbearable amount of discrimination at the hospital from the nurses whom she had known for many years before she had contracted HIV. When her status was found to be positive, she was a patient at the same hospital where she was rejected and ignored by nurses during her treatment. She felt that she was blamed for being promiscuous and developed a phobia for hospitals after this negative experience. Interestingly, the nurses who discriminated her the most were all women. She found it very difficult to cope with her positive status and had difficulty to hug her young niece whom she used to enjoy being together with before she had learned her status. However, her positive status was accepted by most members of her family and friends who knew her well. She found it difficult to tell it to her mother, not due to fear of rejection but due to protecting her mother emotionally.

Example 4: Experiences of a heterosexual man who has been married for many years and who has a young child show that he is well accepted by his brother, mother and father. His wife and son are both negative. His wife felt cheated and questioned him for the route of transmission and couldn't accept his positive status for many years. The wife has not left him and accepted him after several years of going through a difficult time and she cares of him very strongly. He fears of revealing his status in the environment he works at because he is worried that his wife and child may be stigmatized due to his positive status and their lives may be badly affected.

Example 5: Experiences of a homosexual man, who looks masculine and who was married with a woman before, showed that he was also accepted well by friends and some family members. He told his status only to his sister in his family. He preferred not to reveal his HIV positive status to his brother or his mother in his family since he felt that his sexual orientation would be questioned and also revealed. In his experience, he hasn't faced any discriminatory attitudes from health-care personnel who are aware of his HIV positive status.

Example 6: Discussions with a homosexual man, who was never married before and who is in fear of revealing his sexual orientation,[44] showed that he has never told his family about his HIV status. He has shared his status with his male and female friends at the university and within his social network but has hidden it from his father, mother and sister in the fear of being stigmatized as a gay. He has received some discrimination from health-care personnel, such as delay in appointments. For three years, he refused to take medication in the fear of being stigmatized and discriminated at the workplace. None of his colleagues knows either his HIV status or his sexual orientation. He finds it difficult to live a life by hiding his identity.

Would HIV positive men and women be discriminated differently? Would HIV positive women be less discriminated if they behave in conformity to the sexual norms of the society? Would HIV positive men and women who conform to the sexual norms of the society be discriminated less than the ones who are deviant? In

[44] In the Turkish society, marriage is a norm to prove adulthood. Thus, homosexual men feel pressured to get married. Women, who have never been married, are teased, but this norm is changing in the urban areas.

other words, would normalized sexuality act as a moderating factor in HIV-related discrimination and stigma? Would man's sexual orientation be a determining factor for HIV-related discrimination? What are the causes behind different manifestations of HIV-related stigma and discrimination?

The following chapter provides details of the research procedure, findings and discussions and tries to bring explanations to the questions listed above.

CHAPTER 5

MANIFESTATIONS OF HIV-RELATED STIGMA AND DISCRIMINATION IN TURKEY

My observations motivated me to examine the effect of gender on HIV-related stigma and discrimination with selected cases in Turkey. To explore this, I identified normalized sexuality as a moderating factor because I assumed that the sexual norms are built around modesty for women and freedom for men. In order to reach an understanding of the manifestation between gender and HIV-related stigma and discrimination, (i) I conducted in-depth interviews (i.e., qualitative data) with HIV positive people engaged in various sexual behaviors and (ii) I manipulated normalized sexuality with a scenario in a story to capture diversity in the responses of a sample population (i.e., quantitative data). I believed that the combined qualitative and quantitative data would give me a comprehensive profile of the HIV-related stigma and discrimination, encompassing both the views of people who are stigmatized and discriminated against and the views of those who stigmatize and discriminate. A gender perspective was utilized in formulating the design of the qualitative and quantitative data gathering methods and in the analysis of the findings.

5.1. Qualitative Data

In-depth interviews with two HIV positive women and two HIV positive men with various sexual lives were conducted and recorded with their agreement. The interviews were sound-recorded and transcribed to ensure accurate analysis of the interviews. Before the interviews, I prepared a set of questions (see Appendix C) to explore their own perceptions on HIV, how they found out their positive status, what

responses they received from the doctors who explained their HIV positive status, what their thought processes were both upon finding out about their status and later for revealing their status to their family and friends, what the responses of the family and friends, employers and doctors were, how they perceive the relation between HIV and sexuality, and what prejudices they have observed towards people living with HIV (i.e., to find out if they attach gender to HIV discrimination). The questions asked were not leading and the interview was in a conversational manner. After each interview, the interviewees were briefed about the purposes of the study.

Two women and two men who joined in the interviews had the following characteristics[45]:

- **Interviewee 1:** Female, heterosexual, contracted HIV through a marital relationship, loyal to her husband, she was separated from her husband at the time she learned her status, 33 years old, currently has a negative male partner, has lived in a big city. For easy identification purposes in the analysis, I used **Leyla for her** as a nickname.
- **Interviewee 2:** Female, heterosexual, had several male partners before marriage, HIV positive, 26 years old, lived in a small city, currently is married with a negative man and living in a big city. Her nick name in this study: **Pervin.**
- **Interviewee 3:** Male, heterosexual, previously married, had many partners, currently single, HIV positive, 35 years old, has lived in a big city. His nickname: **Tayfun.**
- **Interviewee 4:** Male, homosexual, had many partners, HIV positive, currently has an HIV negative partner, 32 years old, has lived in a big city. His nickname: **Arman.**

5.1.1. Perceptions on HIV before knowing their positive status

Leyla had very little information on AIDS, she only knew it through media and did not know the word HIV. She never ever had thought that it could happen to her. Pervin had good information on HIV, knew the routes of transmission and felt very sorry for people who contracted the virus. She used to think: *"it is such a pity that*

[45] To keep the identities of the interviewees anonymous, more detailed information such as the city they live in currently was not provided in this study.

people would pay such high cost just for having pleasure". Tayfun also had very little information, and what he knew was through media. Arman knew that there were medications for HIV but still had an image of people dying from HIV. All of them had unprotected sex through their relationships. Only, Arman considered himself under risk while none of the others did.

5.1.2. How they found out about their HIV status

All of them found their status when they developed HIV-related symptoms. Leyla was hospitalized, lost so much weight, and yet the doctors could not find the reason for her state. HIV was the last test the doctors conducted on her. Pervin was living in a small city and developed some problems with her lymph nodes on her neck; the doctors conducted many tests and couldn't find out what was happening. The doctor referred her to a specialist and the specialist suggested some tests, but did not tell her what she was getting tested for.

Tayfun was hospitalized and the doctors also had difficulty finding the reason. HIV was the last test the doctor conducted and this was without Tayfun's knowledge. The doctor told him on the phone that he had HIV. Arman, on the other hand, attributed the symptoms he had (such as some rashes on his body and continuous tiredness, etc.) to his possible HIV positive status and he went to a private hospital to get tested.

Their responses show that only Arman considered himself under risk and he voluntarily went to the hospital to get tested. For Tayfun, Pervin and Leyla, the doctors could not initially attribute their symptoms to HIV; and the doctors also did not particularly ask their consent for testing them for HIV.

5.1.3. Responses from doctors and their first thoughts

Leyla was in the hospital with her family when the doctor (male doctor) explained her that she had contracted HIV. He did not ask any questions to Leyla about her life or how she had contracted the virus, but he immediately told her that she shouldn't worry; and that there are now medications for HIV and she will be OK. The doctor was a friend of her father and he had already shared this information with the father

before discussing her positive status with her. This indicates that the doctor tried to protect her from any negative feelings or emotions and provided very good treatment and care. Leyla could not associate herself with this virus and felt that she contracted this virus "out of her control". The first thing that came to her mind was that this was a "*disaster for the whole family"*, which indicates that she considered HIV coming to her family, not to herself only, indicating that she did not think of any possible discrimination from her family. For her, AIDS struck the whole family unit. She felt at the time that only people with inappropriate behaviors would contract this virus. She later had thought that if she had had to explain her status to her family by herself, she would have felt quite sad and experienced difficulty since her husband was chosen by her family for her arranged marriage. She thought that the family would blame themselves for her contracting HIV because they married her to him.

She wrote a poem upon discovering her status in the hospital, which is very illustrative of her feelings and her fears towards HIV:

Mom!

I am still a little girl, little and innocent.
In need of your hugs and your smell,
The man who had big hands that you married me to,
Poisoned my blood.
I was unaware, I was helpless.
Now you learned my name, my blood.
MOM! Am I still your little girl?

The findings from this interview give strong clues about the gender construction and patriarchal culture in Turkish society and the HIV-related stigma and discrimination. The father had the authority to marry his daughter and the daughter obeyed the rules of the family to marry a man when she was 17 years old. The husband, who assumed responsibility for her protection, is illustrated with "big hands" and she thinks of herself as a "little girl", still in need of protection. In other words, the woman was transferred to the husband by the father to be protected and she had no control of her life and her sexuality. The doctor, as a man and a friend of the father, also showed a protective attitude towards the woman as he immediately told the

woman's positive status to the father, indicating that the father has the responsibility for taking care of her. The doctor's behavior (i.e., allocating the power to the man, who is the father in this case) demonstrates women's subordinate position in the culture. Her sexuality (even though she was separated from her husband at the time when her HIV status was found) was not questioned even once, which indicates that she was assumed to contract the virus through her marital relationship. It also shows that Leyla assumes her gender role, accepts her positive status in an obedient way, and assumes that the family would blame themselves, not her, for her contracting the virus. In other words, the father and the husband are responsible for her sexuality.

Pervin found her status very casually from a lab technician, when the technician said "*oh, you are that woman*", and she asked "*which woman?*" while noticing that the nurses and people around her were all well aware of what was going on. When she asked what was happening, the lab technician said "*well, they found AIDS in you, that is why everybody is a bit nervous*". So, she immediately went to the doctor's room (male doctor), knowing the answer already, but decided not to say anything. The first question that the doctor asked is "*what does your husband do?*" she answered that she was single, not married. The next questions were for inquiring other things such as if she had had any blood transfusions before or had any tooth extractions. Then she questioned the doctor if they had found AIDS in her, and the doctor smiled her and asked "*why would you think such a thing*?" without showing any discriminatory or judgmental attitude. The interesting finding here is that the doctor immediately assumed that she was married and contracted HIV through a marital relationship. When she said that she was single, the doctor still did not attribute HIV to her sexuality and asked her if she had contracted the virus through other possible routes of transmission, such as through blood transfusion. This again shows that woman's sexual life is not even a question in the culture if she is single and the woman is expected to experience sexuality only within wedlock. This is the norm for women in the society.

The first thing Pervin thought was how she would explain her positive status to her family. She said "*everybody knew that I was single so they would think that I was a virgin. I wouldn't feel this sorry if I got pregnant, because that has a solution, you*

get an abortion and you solve the problem. But this will stay with you all your life". She expressed her feelings such that she had destroyed the honor of her family; she did not want her father and her brother to walk in public with their destroyed honor due to her, and she had abused the "trust" that her mother had for her. She said "*I had this virus due to my promiscuous behavior so I had to deal with the burden myself*". She wanted to protect her family's honor so she decided to run away before her father or brother would ever learn about this. This indicates that she constructed gender norms for women's sexuality, such as the "value for virginity", and "trust with her mother" and "honor for her family through her virginity". She assumed responsibility for contracting the virus, blamed herself and did not blame her partners. She was ready to face anything in her life due to that, almost ready to punish herself for contracting this virus. The difference between Leyla's and Pervin's reactions was that Leyla did not blame and discriminate herself, since she thought that she followed the norms of the society, but Pervin did blame and discriminate herself due to her perceived "promiscuous" behavior. Obviously, patriarchal power structures in the society shape these attitudes.

Tayfun found his status on the phone very casually while walking on the street, when the doctor (male) explained his status; Tayfun got quite angry, yelled at him and then almost collapsed on the sidewalk. A pharmacist observed that he wasn't feeling well so he came by and invited him in to sit down and feel better. Tayfun later associated himself with a Bulgarian-Turkish weight lifter, *Naim Süleymanoğlu*, in the sense that he first collapsed but stood up as a strong man again. He attributed his infection to one of his many relationships he had had with the "Russian girls". He called his friends, and brother to tell them that he got AIDS and went to a pub for drinking and thought "*I will die of alcohol, not from HIV*", trying to beat HIV in some sense. His friends and brother came to the pub to take him away late that night. He received quite good support from his family and friends and revealed his status to so many people around him. The findings indicate that the doctor told his status on the phone in a normal way, not providing any extra support, Tayfun's responsed involved masculine roles such as aggressiveness and power first- but collapsed on the sidewalk. Later, he associated himself with *Naim*, a strong weight lifter, who resembles a strong man. It is also interesting that he did not consider contracting the

virus from any of the Turkish women he had been with, but associated the virus with the "Russians".

The normalized sexuality again shows itself that (i) Tayfun did not hesitate to reveal his HIV positive status to his family and friends, indicating that he did not expect that they would blame him for contracting HIV through sexual relationship, (ii) he immediately assumed that he had contracted the virus from a Russian woman, but not from a Turkish woman (indicating that sexuality is not 'normal' for Turkish women). This may also shows his sexual freedom and territory being expanded which may indicate his increased power and strength, (iii) His sexual freedom caused him contracting the virus, which he accepted. His response shows that it is a power struggle between him and HIV.

Arman found out about his status at a private hospital after he got his voluntary test. Later, he went to a state hospital and had to fill in a statistical form that was for monitoring purposes. He did not feel that he felt any pressure from the doctor. He said "*I was very scared at that point and the only person who could help me was the doctor. So, I tried to be open with my doctor as much as possible, and I had to give very accurate information to him so that he could help me*". Arman's response indicated that he was experiencing fear of unknown, fear of death, and helplessness and was hoping for help. He thought that the only person who could help him was the doctor. Opposite to Tayfun, he tried to be very open to the doctor about his sexuality, about his life, so that the doctor could help him. He did not fight with the virus but allocated the power to the doctor. He showed a much softer response compared to Tayfun, and tried to receive help instead of trying to prove his strength and power.

Arman decided to keep his status as a secret, started making plans for his death, such as quitting his job, moving away from the house and going to a hotel to wait for his own death. He wanted to protect his family from the social burden that this infection brings. This is almost similar to what Pervin was thinking. He decided that if he had to tell anything to his family, he would tell them that he had cancer. This indicates that he perceived his positive status due to his homosexual relationships, which he

could not explain to other people. He thought he would die immediately, even though he already had known that there were some medications. This possibly indicates discrimination against himself due to contracting HIV through homosexual relationships.

In summary, two people, Leyla and Tayfun did not discriminate themselves upon finding out their positive status. Their responses indicate that they behaved "normal" and within the gender norms that are constructed in the society. On the other hand, Pervin and Arman both discriminated themselves and wanted to leave their family as an indication of punishing themselves for their "deviant" sexual behavior. The doctors did not allocate responsibility to women for contracting the virus, indicating women's subordinate status and normalized sexuality of women in the culture. One more finding is that Tayfun showed anger whereas Pervin and Leyla behaved emotional. This finding supports the study that HIV positive women were more likely to keep their emotions inward, whereas men expressed their anger in the response to stigma (ACORD, 2004).

5.1.4. Responses from family, friends and employers

The responses of families were all supportive except for that of Pervin's. The mother of Pervin blamed her for "*abusing her trust*" and Pervin also agreed with her mother that she had abused the trust between she and her mother. This is very interesting that the patriarchal culture shapes the norms for women such that these norms become means of control. For example, the norm "girls keep their virtue", and "if they don't, they abuse the trust of their family, and they destroy the honor of the family" is expected to be strictly followed by girls. This norm becomes a self-control mechanism for the members of the gender. This finding provides support to the discussions of West and Zimmerman (1991) that members of each gender get involved in self-regulation as they start monitoring their own behaviors and those of others, and form "gender identities" that are important to individuals to maintain in the society they live in. In this case, the trusting relationship between the mother and Pervin indicates the existence of a self-control mechanism for women's sexuality.

Pervin was very worried about her father's reaction if he had ever found out about her status. She thought that she would be beaten up by her father (with an *Osmanlı dayağı*--Ottoman style beating). This shows that violence also appears as a control mechanism. As she felt that she had destroyed the honor of the family, she eventually left her home, the protected environment and ran away to a big city to continue her life as a single woman. In opposite, Leyla's family did their best to relieve her pain and provided strong support to their daughter--Leyla, did not destroy the honor of the family, or she did not abuse their trust.

The family of Tayfun also provided strong support, especially, the sister-in-law, and the brother. The sister-in-law cried on the phone on one of their discussions, and Tayfun said "*there is no reason for you to cry, I only want to swim one more time and die*", indicating that he is strong, he can face death and nobody should feel sorry for him. He only wanted to swim, which he likes, maybe a sense of freedom and strength to feel. His brother felt quite sorry and took care of him and provided financial support to him for many years. This indicates that his sexual behavior was accepted and HIV only came as a surprise or by chance.

The sister and brother of Arman felt quite sorry for his HIV status. During their discussions, Arman also revealed his sexual orientation which was a relief for him, as he describes. He, however, did not reveal his HIV status to his mother, worrying that her mother's health status would not be strong enough to know his positive status. This shows that he wanted to protect his mother, but also he wanted to protect the "family's honor" as he mentioned previously. His responses indicate that the siblings did not blame him neither for his HIV status nor for his sexual life, and it is possible that this may be due to men's sexual freedom in the culture.

Friends of Pervin, Leyla, Tayfun and Arman all accepted their friends' status and provided a lot of support. For example, when Pervin learned her status, she phoned to her cousin, and asked her to learn about HIV on the net. Her cousin searched the web and told the information on HIV to Pervin. Both cried on the phone when they talked about the symptoms of HIV and what was waiting for her in the future. Neither Leyla nor Pervin had any problems while revealing their status to their friends.

Arman felt that revealing his status brought a burden to his friends because they liked him so much and they felt sorry for him. These three people chose the kind of friends whom they wanted to share their HIV positive status. Tayfun, however, told to so many people about his positive status within a very short time (he said he was in a shock at the time he learned it), and received instant support from many; some of the friends of Tayfun somehow slowly disappeared from his environment.

The responses from the people around the interviewees, such as their employers and co-workers, varied. For Leyla, her previous boss (female) gossiped about her and tried to spread the information to her colleagues and friends informally and without her consent. However, instead of excluding her, almost all her colleagues and friends called her and asked if there was anything they could do. These people were mostly males, but were also females. When she changed jobs, she told her status to her new boss (male); her boss said that "she is like his sister" and he would be happy to provide any support if he can. This shows that people in her environment, except for her female boss, did not show any discrimination towards her. The male boss relating her with "his sister" shows that "she did not do anything wrong" within the patriarchal family norms. He assumed the role of protecting her, which again can be explained within the patriarchal power structures in the society.

After Pervin was rejected by her mother, she moved to a big city, dated with a man that she had known from her childhood. When her boyfriend proposed her, she was quite worried because it was time to reveal her HIV status. She told him that she will tell him something and he was free to leave the relationship after their discussion. She told him that she was HIV positive and that it was because she had a promiscuous life before (*hızlı yaşam*). He first paused and said "*so what, it only means that there will be a piece of shield between us*", showing a very supportive attitude. They are now married and have a very good relationship. Pervin found a job in the big city and she wanted to share her status also with her boss (male). She revealed it to her boss (male) mentioning the same reason she had told to her boyfriend (promiscuous life style). The boss felt quite sorry for her and immediately suggested to include her in the insurance plan since she may need medication for treatment. This may be somehow surprising that she was not discriminated by her

boss, even though the boss learned her 'promiscuous' sexual behavior. Both of these men indicate a very non-discriminatory and protective behavior towards women. Possibly, in Pervin's case, she was perceived single and lonely by her boyfriend and needing protection in a big city, and he assumed the protective role towards her. Whereas when she revealed it to her boss, Pervin was already married, she had a man who was responsible for her, indicating that she is accepted and protected by a man. This acceptance may indicate a status for the woman in the patriarchal culture. In any case, Pervin was not discriminated by men due to her previous sexual life as one would expect.

Arman did not reveal his status in his work environment, indicating that he expected discrimination from his co-workers. Tayfun, at first, revealed his status to everybody around him, and later he locked himself home for three years, feeling depressed and did not have sexual relations for many years. Later, he decided to start a business and he had partners for his new business. By then, he had been living with HIV for three years already. Here, he wanted to share his status with others, told it casually, and saw that people got quite scared, so he immediately switched his words and told that it was a joke. But, instead, he said that he had cancer. They now all believe that Tayfun has cancer. It is interesting that since he had been living with HIV, he formed a different identity towards HIV.

As all of them received much support from close friends which may indicate that physical and emotional proximity in relationships may moderate the level of HIV-related stigma and discrimination in the Turkish society. This is parallel to the findings of a study conducted in Turkey where interpersonal contact with homosexual men and women was found to be associated with positive attitudes towards gay men and women (Gelbal and Duyan, 2006). The results of an HIV-related stigma reduction project implemented by the Positive Living Association in Turkey in this past year (2007) also provided support to this finding. The project clearly demonstrated that when the familiarity with an HIV positive person is

increased, the physical and emotional distance will be decreased, and accordingly, stigma and discrimination towards HIV positives will also be decreased.[46]

One interesting finding here is that the motivations for revealing HIV status seem to differ for four of the people. Leyla and Pervin reveal their status "to be honest" and "to receive support", in some sense similar to Arman's motivation. Whereas for Tayfun, finding out was a surprise and revealing was almost like a demonstration of his "manhood". Therefore, confession for girls also appears as a control mechanism for their behaviors in the culture.

5.1.5. The relation between HIV and sexuality for the interviewees

All interviewees connected HIV with sexuality, but Arman was the only person who thought it could happen to him. Arman, Pervin and Leyla all think that the sexuality component of HIV is quite strong and people judge others based on their sexual behaviors. Leyla thinks that if she had not contracted HIV through a marital relationship, she would have had received judgmental responses from the society. She said that she can see people waiting to find out how she had contracted HIV, as if that is a turning point for them either to discriminate or to empathize. Interestingly, she is now dating with an HIV negative man, who accepts her and provides a lot of support. However, she is now the "positive girlfriend of a negative man", and thus has a different identity than her previous identity. She now hides her status from his friends in the environment because she thinks that the friends of her boyfriend may say "*how could you date with such a woman*" to her boyfriend. She mentioned that contracting HIV through her marital relationship does not count any more. As long as there is a man beside a woman, either a husband in marital relationship, or a father, she is protected and not discriminated. However, dating with a man that she is not married to shows the possibility that she may have sexual relationship out-of-wedlock. Therefore, she feels that being HIV positive now puts her in the "inappropriate category" and makes it possible for her to be easily stigmatized. Thus, she has experienced two different roles as a woman, "appropriate"

[46] Supported by UNAIDS, Positive Living Association in Turkey has been conducting seminars at medical and dental faculties with involvement of people living with HIV. As revealed by the results of pre and post-test questionnaires, the informative seminars reduce the emotional distance between participants and the person living with HIV. Also, the participants approach and shake hands with the HIV positive speaker after the seminars.

while previously married and now, "inappropriate" dating with a man. In her own surrounding, she can share her status with others because she is known in the "appropriate" category, but in her boy friend's surrounding, she may be put in the "inappropriate" category, so she hides her status from his friends. The culture thus puts pressure on her to keep her HIV status as a secret since this would be an indicator for her sexual freedom, which is not perceived well in the culture. This shows that having sexual freedom after a divorce has changed her identity and she perceives herself differently, outside of the gender norms (having sexuality out-of-wedlock).

Pervin now knows that HIV can find anybody unexpectedly and comes from unprotected sex. However, she still thinks that homosexuals are under more risk. She has experienced two roles as a woman in the society; "inappropriate" when she was single and contracted HIV, and now "appropriate" as she is married. She finds it easier to reveal her status now that she is a married woman. She explains this as, if a woman is married, she is not perceived as a threat to the society for spreading HIV. She believes that if a woman contracts HIV from her husband, the society accepts her much more easily. She says:

> *There is more prejudice towards women in the society for sexuality because sexuality out-of-wedlock is a taboo for women in the society. In opposite, there isn't such a belief for men. If a woman contracts HIV out-of-wedlock, it is assumed that she has shown promiscuous behaviors and not surprisingly contracted HIV, whereas this attitude is different towards men. People would think that he has been a playboy (çok yaramazlık yapmış).*

It is also interesting to note how Leyla and Pervin's changed sexual behaviors shift their identities indicating a pressure due to the norms within the patriarchal structure in the Turkish society.

Arman stresses that the information on HIV is not shared openly in the society. For example, even though HIV is not deadly anymore (due to the availability of advanced medications), disseminating this information would cause people to stop fearing HIV, so he believes that this information is not shared in public. He points

out that scaring people (i.e., scaring people with HIV-related death) is one method by which people think that HIV transmission can be reduced. He adds that spreading fear is one way of sustaining power in the society, so that the dominant powers can impose their norms in the society. Arman also thinks that there is a difference between discriminating against a positive married woman, positive woman in sex industry and a positive transvestite. He believes that the transvestite faces the highest level of discrimination in the society. He says:

> *The married woman is a victim in the eyes of the society. But people think that the other woman deserves it since she works in this field (meaning selling sex). Actually, transvestite is the one who deserves HIV the most in the eyes of the society. For an HIV positive woman in sex trade, people sometimes think that she has fallen in life already and she has had one more unfortunate occurrence by contracting HIV (kader kurbanı, düşmüş, bir şanssızlığı da bu olmuş). For a heterosexual married man, the society sees him as a playboy who has contracted HIV while cheating his wife. He may be discriminated due to his HIV status but not due to his sexual behavior.*

Arman touches the taboos in sexuality and perceptions of the society towards women and men with various sexual behaviors. What is interesting is that the woman in sex trade, he says, receives sympathy from the society, which means that she has not been protected, or her guardian failed to protect her. In the case of a transvestite, the man's gender is not matching to his biological sex and he lives as a woman. His status may reflect gender based discrimination that "a man cannot be a woman". This may indicate that the member of a higher status, meaning man, chooses to be the member of a lower status, meaning woman, and this may explain within the patriarchal norms that he definitely should be discriminated at a higher degree (i.e., because a man wanting to become a woman is lowering down men's status).

One of the interesting comments came from Leyla:

> *Why would a man want to marry a virgin? Because he wants a woman who has never been touched before and he should be the only one that makes a woman experience sexuality. He has the belief that he should have this power only, but he usually is not virgin himself. If one man is a virgin in his*

twenties, it is a topic of teasing/joking. It doesn't matter what he has accomplished intellectually or with his brain, instead he is valued with how he has proven his manhood. This happened to one of my friends, who was 25 years old, while a group of us was having a dinner together. Upon finding out that he was still a virgin, all the men at the table laughed and said "shame on you, how a man can hold himself up to this age (yuh yani, bu yaşa kadar kalınır mı).

Leyla's observation demonstrates how the meaning of virtue differs for a man and for a woman. Within the constructed gender, virginity is a norm for the woman, and sexual power is a norm for the man. Proving manhood is demonstrated with sexual behavior for men, thus sexual promiscuity of men is reinforced in the society.

In summary, respondents all provided supportive information that gender has an effect on HIV-related discrimination. Normalized sexuality becomes a moderating factor in the sense that women contracting HIV through a marital relationship and men contracting HIV through a heterosexual relationship can better share their HIV status with their families. An unexpected finding was that both women met HIV negative boyfriends, and both of them have been well accepted and not discriminated. This may be explained by men assuming the role of "guardian" for protecting women within their constructed gender in the patriarchal structure in Turkish society.

The next section describes the quantitative results of the study. The role of women in the society as the subordinate, needing protection and care, and being discriminated less is also shown to be supported by the quantitative data.

5.2. Quantitative Data

Through my observations during my work with UNAIDS and through the four in-depth interviews conducted, I found significant differences in how people discriminate and how they are discriminated against. I was quite interested to examine whether the findings of the four interviews would be consistent and wide spread in a sample population. With the quantitative data, I aimed to see the effect

of gender by looking if the discriminatory responses of a sample population would change based on the sex and sexual behaviors of a person living with HIV. By combining qualitative and quantitative data, I wanted to look at the two sides of the mirror to develop a better understanding for the effect of gender on HIV-related stigma and discrimination in the Turkish society.

Would an HIV positive woman loyal to her monogamous relationship (like Leyla) be discriminated the least by the respondents? Would the respondents discriminate HIV positive women (like Leyla and Pervin) and differently than HIV positive men (like Tayfun and Arman)? Or, would the respondents discriminate HIV positive man and woman who conform to the sexual norms of the society (like Leyla and Tayfun) any differently than who do not (like Pervin and Arman)? Would man's orientation be a determining factor in the HIV-related stigma and discrimination? To test these ideas, I developed a scenario with four versions, each of which has one character displaying similar sexual behaviors to Leyla, Pervin, Tayfun and Arman. The questionnaire was designed in a way that each respondent would answer the exact same set of questions after reading the scenario that involved one of the four characters. I expected that the ratings of the respondents would change based on the sex and sexual behaviors of the Characters in the scenario. The model and the comparisons to be made are shown in Figure 1 below.

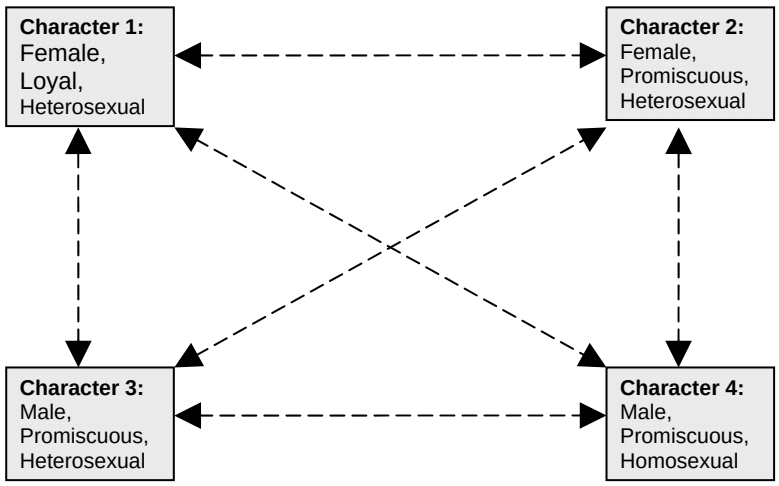

Figure 1: Comparisons of the discriminatory ratings of the respondents towards HIV positive characters

In order to test if people who displayed normal sexual behaviors would be discriminated differently than people who displayed deviant sexual behaviors, I modified the above model such that the man and woman characters in the scenario that behaved according to the sexual norms of the culture would be in the "normalized sexuality" group, and the man and woman characters in the scenario that behaved against the sexual norms of the culture would be in the "deviant sexuality" group. This model is shown in the figure below. The difference between the discrimination ratings of the respondents against the two groups would allow me to understand whether the respondents would discriminate against the characters in the scenario based on their sexual behaviors.[47]

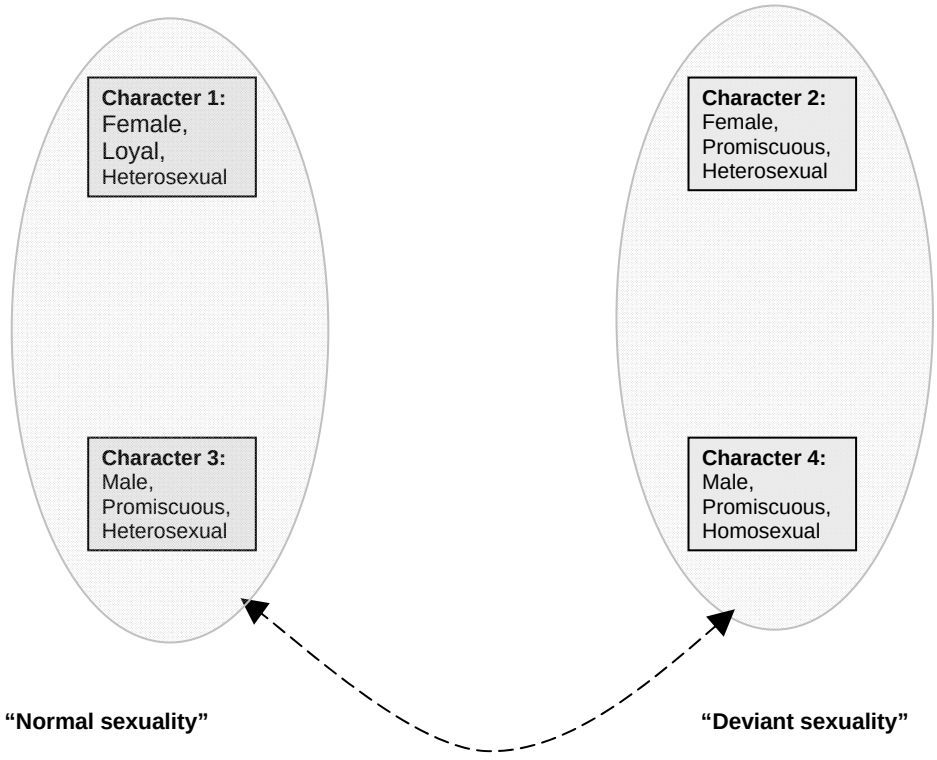

Figure 2: Normalized Sexuality: Discrimination based on normal sexual behaviors versus deviant sexual behaviors

[47] Loyal female (Character 1) and promiscuous heterosexual male (Character 3) were considered as following the normalized sexuality, and the others (Character 2 and 4) would be following the deviant sexuality. This study used this assumption and looked at the discrimination rating difference among the two groups. Thus, loyal heterosexual female and promiscuous heterosexual male (i.e., Characters 1 and 3) which are assumed to fit into normalized sexuality category, were grouped together into a "normal sexuality" category. Promiscuous heterosexual female and promiscuous homosexual male (Characters 2 and 4) were grouped together into the "deviant sexuality" group. A t-test was conducted to test this prediction.

5.2.1. Respondents

The respondents of the study were two hundred fifty-three students from 1st, 2nd and 3rd year dentistry courses at the University of Istanbul, Dental Faculty. The percentage of male and female respondents was very close to 50% (see Appendix B for descriptive statistics).

Dentistry students were selected for this study because I expected that these students were likely to have received HIV/AIDS information during their studies, and their level of knowledge would be relatively standardized (compared to a truly random sample out of the general population). Also, being a former dentistry graduate, I had familiarity with this sample group. The questionnaire included a section to measure the knowledge of the respondents on HIV since lack of knowledge and fear has been identified as a factor to cause HIV-related discrimination.

Students were from various cities in Turkey. Based on the demographic findings, it was seen that this group of students was a representative sample of an elite, educated group, and it should be noted that it may not be a representative sample for the whole Turkish society.

The students took part in the study during their class hours with the permissions obtained from the Vice Dean of the Faculty and professors of their classes. The current hypothesis on the effect of gender on HIV-related discrimination and normalized sexuality as a moderating factor was tested through self-administered questionnaires.

5.2.2. Design

The survey in this study aimed to find out how strongly the respondents discriminated against people living with HIV based on their sex and sexual behaviors in a given scenario.

The scenario described a childhood friend of the respondent named Deniz,[48] who recently got married. Deniz and the respondent still see each other and work together part-time in a pharmaceutical company. Deniz wants to talk to the respondent one

[48] My background in psychology research helped me design this original scenario based on the anecdotal information from the interviews and from my work with people living with HIV.

day after work and tells that he/she just got a blood test done and found that he/she is HIV positive. Deniz is quite worried about other people hearing this since he/she is not sure what others would think of him/her so Deniz particularly asks the respondent to keep this as a secret.

I expected that the respondents would react differently based on Deniz's sex and sexual life, just like in the interviews of people living with HIV. So, I manipulated the sex and sexual behavior of Deniz in order to be able to capture differences in their discriminatory responses. [49] To manipulate these in the story, I put one of the four explanations below on Deniz's sex and sexual life:

- **Character 1 (similar to Leyla):** a loyal woman who has never had a sexual relationship except with her husband (sexuality within wedlock),
- **Character 2 (similar to Pervin):** a woman who has had other sexual relationships before getting married (sexuality out-of-wedlock, called promiscuous due to the cultural norms),
- **Character 3 (similar to Tayfun):** a promiscuous heterosexual man who has had other sexual relationships before getting married,
- **Character 4 (similar to Arman):** a promiscuous homosexual man who has had other relationships before getting married.[50]

After reading one of the above four scenarios, the respondents answered the self-administered questionnaires which included three sections to measure their discriminatory attitude towards Deniz, their attitude towards sexuality of men and women in general, and their knowledge on HIV/AIDS. I wanted to measure their

[49] This study used a factorial design of 2 x 2 x 2 (two independent variables with 2 levels x one subject variable with 2 levels). The terms independent and dependent variables are used in an experimental design to refer to the variables studied. Independent variable is defined as the "cause" and the dependent variable is defined as the "effect". Independent variable is manipulated in experimental designs to see the effect. Subject variables are defined as the characteristics of individuals, such as sex, etc. which are standard variables and are not manipulated (Cozby, 1992). In this design, the independent variables are the sex and sexuality of the characters living with HIV in the scenario. The sex of the respondents (male or female, being 2 levels) is chosen as the main subject variable. The dependent variable was the discrimination ratings of the respondents, based on each scenario (i.e., one out of four) in the self-administered questionnaires.

[50] As I have observed through my work, many homosexual men in the Turkish society get married for not being stigmatized as 'homosexuals' and to prove their 'manhood' to the family.

discriminatory attitude and behavior, as well as their knowledge on HIV so that I would be able to look at the relationship between discrimination and lack of knowledge.

As shown in Figure 1 above, promiscuity and loyalty were the differing characteristics between females (similar to Leyla and Pervin). Heterosexuality and homosexuality were the differing characteristics between males (similar to Tayfun and Arman). Sexual freedom was differing between males and females. Also, discriminatory ratings against two characters showing normal sexual behaviors (similar to Leyla and Tayfun) versus the other two characters showing deviant sexual behaviors (similar to Pervin and Arman) were compared. Each character is married in the scenario, and all characters were given the same gender-neutral name (Deniz) to eliminate any confounding variables.[51]

5.2.3. Sections in the Questionnaire

The questionnaire had four sections that served to gather the following data:

1. Demographic information: The first section in the questionnaire gathered data on age, sex, mother's and father's education, mother's and father's type of job, number of the siblings, the size of the city or town or village that the respondents were raised in, the level of foreign language skills they had, the type of high school they attended to, the type of residence (with family, shared with friends or relatives, dormitory), and the respondents' experiences in foreign countries.

2. Discrimination Data: The second section in the questionnaire had a set of 10 questions to measure the discriminative attitude of the respondent towards the HIV positive person in the scenario. All questions were directly related to the respondent's reaction towards his/her friend after finding out the positive status of his/her friend, such as (i) comfort level about working in the same office, (ii) desire to warn the others in the office about Deniz's HIV status, (iii) shaking hands with

[51] In the experimental designs, each condition is kept similar to avoid any confounding. Confounding happens when extraneous variables other than the intended manipulated variable interfere and blurs the results (Cozby, 1992).

Deniz, (iv) kissing on the cheek, (v) sharing the same toilet, (vi) judging her/his sexual behavior, and (vii) deciding whether his/her friend deserved this virus.

All of the questions were developed based on the anecdotes of people living with HIV in Turkey and my observations through my work and personal experiences with PLHIV. These questions are as follows:

1) Would you now avoid seeing Deniz?
2) Would you worry that you have contracted this virus because of working in the same environment with Deniz?
3) Would you do research on HIV and AIDS to provide support to Deniz?
4) Would you think that Deniz contracted this virus due to his/her inappropriate behavior?
5) Would you think that Deniz should not reveal his/her status to his/her family since the family may reject him/her?
6) Would you feel uncomfortable to work in the same environment with Deniz?
7) Would you warn others in the office environment telling that Deniz is HIV positive?
8) Would you avoid kissing Deniz on the cheek from now on?[52]
9) Would you think that Deniz has an inappropriate sexual life?
10) Would you think that Deniz deserved this virus?

The responses were either a "yes" or a "no": each response received a score of 0 for no discrimination against the person living with HIV and score of 1 for discrimination in each question. I expected that if the sexual life of Deniz is approved by the respondent, then the respondent would give non-discriminatory ratings. For example, he/she would continue to see Deniz (0 score), would think that Deniz did not contract this virus due to her inappropriate behavior (0 score), etc. The total score of discriminative responses for these 10 questions was totaled to form the *"discrimination index"* for this study, ranging from 0 (no discrimination) to 10 (high

[52] Kissing on the cheek is a very common social behavior both for men and women in Turkey.

level of discrimination). Each respondent's discriminatory attitude was assessed with the total discrimination score[53].

The respondents were asked to leave the questions blank if any of the answers was not satisfactory (see Appendix D for survey questionnaires).

3. Norms on sexuality: The third section involved a set of 3 questions that searched the views of the respondents on sexual norms (i.e., acceptance of homosexuality, acceptance of promiscuity for males and for females):

1. Would you continue to see a male friend of yours upon finding out that he is homosexual?
2. Do you think that it is acceptable for a man to have sex with many partners before getting married?
3. Do you think it is acceptable for a woman to have sex with many partners before getting married?

The first question had a "yes" or "no" answer, and second and third questions had three choices including: "yes", "yes if he/she had protected sex" and "no". Each question was scored as "0" for a liberal view towards sexuality, "1" for middle, and "2" for conservative view towards sexuality. These scores from each of the three questions were summed to form the *"conservative index"* for this study, ranging from 0 (liberal view on sexuality) to 6 (conservative view on sexuality).

4. Knowledge on HIV/AIDS: The fourth section utilized a test consisting of 11 questions on HIV/AIDS, adapted from the UNAIDS Interactive HIV/AIDS Training CD (UNAIDS, 2002)[54], to measure the respondents' knowledge on HIV/AIDS. The questions tested the respondents' knowledge on transmission of HIV through: casual

[53] Before deciding on a 'yes and no' scale, these questions were tested with a 5 point scale answers among a group of masters students who provided feedback. The students mentioned that it would be easier to answer with either a 'yes' or 'no' and be precise and eliminate the 5 point scale. In order to develop a reliable index, at least 10 questions were needed. Therefore, the discrimination index was formed by using a set of 10 'yes and no' questions to in order to be able to measure the differences in discriminatory attitude of the respondents.

[54] This interactive training CD was adapted to Turkish society and has been used as a learning tool in the country. The questions on the CD are commonly used for testing knowledge on HIV/AIDS.

relationship, unprotected sex, mother-to-child, using the same utensils, sharing a bathroom, coughing or sneezing, mosquitoes and sharing the same phone. The answers were again in the form of "yes" or "no", and respondents received a score of "0" for each correct answer and "1" for each incorrect answer. The scores of these 11 questions were summed and the total score formed the *"ignorance index"* for this study, ranging from 0 (very knowledgeable) to 11 (very ignorant).[55]

5.2.4. Procedure

Two experimenters,[56] accompanied by professors of the corresponding classes, simultaneously delivered the questionnaires in each class. The experimenters explained the purpose of the study, assured anonymity, confidentiality and voluntary participation. The self-administered questionnaires were delivered to the classes of 2nd and 3rd year students at the same hour on one day, and to the classes of 1st year students at the same hour on another day. In this way, the likelihood of one group of respondents discussing the survey with any of the other respondents was minimized.

In order to assure anonymity, names of the students were not asked and questionnaires were collected all at once. In order to guarantee their voluntary participation, students were given the choice of filling-in or leaving the questionnaires empty, if they desired to do so. Students were also asked to leave the questions blank if the question did not have a satisfactory answer. Two out of 255 students left the questionnaires blank.

In general, the questionnaires were filled in with great interest by the respondents. After completing the questionnaires, a debriefing was made by the experimenters who were knowledgeable on HIV/AIDS. Since the respondents asked many questions, an interactive discussion on HIV/AIDS occurred after the experimenters

[55] In this series of questions, two identical questions were included at the beginning and towards the end to check whether respondents were carefully and truthfully answering the questions. This was validated since all the respondents gave the same response to these two questions.

[56] I was one of the experimenters and the other was one of my friends who previously worked as a consultant for UNAIDS in the previous year. She is also a member of the Positive Living association who is quite knowledgeable on HIV/AIDS issues. We each went to one class simultaneously. Two professors were the teaching assistants at the university who were asked to help us by the Vice-Dean of the Dental Faculty.

provided information on the purpose of the research.[57] The basic data and the main findings of the study are summarized below. The complete set of graphs and tables from the statistical analyses[58] are provided in the figures in Appendix B.

5.2.5. Demographic Profile of the Respondents

The number of females that participated in the study was 126 (49.8%) and the number of males was 127 (50.2%). The age of the respondents ranged between 17 to 31 years, with the majority (76.3%) being from 19 to 21 years old. The majority of the students had either one (41.1%) or two siblings (27.7%), and the number of siblings ranged from 0 to 24 - 7.2 % had none (18 respondents) and 0.4% had 24 (only 1 respondent).

Except for a small percentage of students growing up in villages or small town (4.7% village, 6.7% small town), most students either grew up at a small city (45.5%) or a large city (42.7%). Only 15.4% of the students studied in normal or super high-school, and 60.5% graduated from Anadolu, 14.6% from Science, and 9.5% from private high-school. The perceptions of the respondents for the level of language skills they had were found to be 10.3% weak, 43.1% middle, 37.2% good and 9.5% very good. A large majority of students (72.3%) had never been abroad for any purpose, whereas 22.1% went abroad for pleasure and only 2.8% studied and 0.4% did internship in a foreign country.

The information on their residential status of the respondents showed that most students lived with their families (52.2%), followed by at dormitories (24.9%), with friends (13%) and with relatives (9.1%). This finding showed that over 60% of students live with family and relatives, which may reflect the protective attitude of the Turkish society.

[57] After this survey students showed high level of interest and four seminars were conducted by UNAIDS and Positive Living Association in the following months, to raise awareness on HIV/AIDS and to reduce discrimination and stigma towards people living with HIV. A person living with HIV attended to the seminars and pre- and post questionnaires were utilized to measure the students' knowledge, behavior and attitude. It was seen that these seminars were very effective for stigma reduction.

[58] SPSS version 11.5 was utilized for the statistical analysis of this study.

The educational opportunities of the mothers and fathers of the respondents were found to be quite different at the university and elementary levels; 49% of fathers received university level education compared to 27.7% of the mothers, and 33.6% of the mothers had elementary school education compared to 15.8% of the fathers. Thus, more women graduated from elementary school, and less from the university. The percentages for middle school were 11.9% for mothers and 8.7% for fathers, for high school were 25.7% for mothers and 26.5% for fathers. This is shown as below:

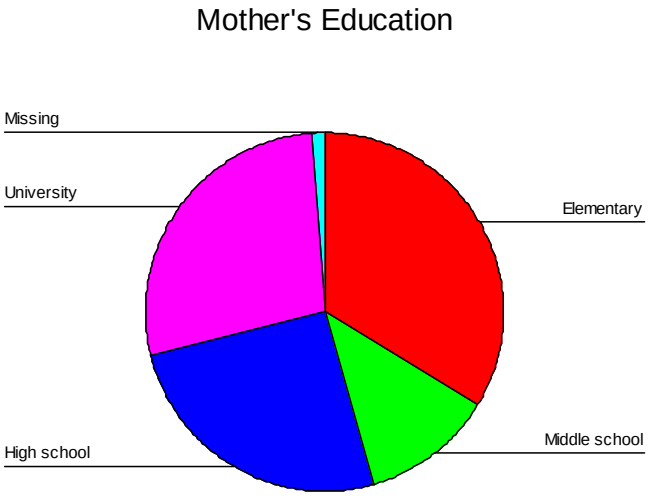

Figure 3: Mother's Education Level

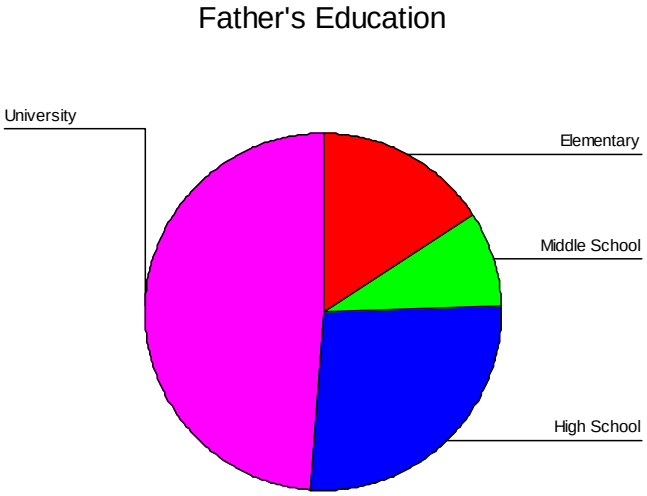

Figure 4: Father's Education Level

This supports the understanding that women have less access to higher education in Turkey.

5.2.6. Discrimination Ratings of the Respondents

Similar to the qualitative data, the respondents gave different responses based on the four different scenarios, indicating a shift in their discriminatory attitude and behavior towards the character based on the character's sex and sexuality.

5.2.7. Discrimination Index Questions

Before analyzing the results of the total discrimination ratings,[59] I will examine some of the interesting findings in more detail (please note that each of these answers form part of the discrimination index).

A. Some of the findings from the questions included in the *discrimination index*:

1. **Would you now avoid seeing Deniz?** If Deniz was the loyal female in the scenario, 8.3 % females and 8.7 % males would avoid seeing Deniz. If Deniz was the promiscuous female in the scenario, 16.1% females, and 6.9 % males would avoid seeing Deniz. When Deniz was the male heterosexual in the scenario, none of the females and 23.1 % males would avoid seeing him, whereas all of the females would continue seeing Deniz, indicating a high level of acceptance towards the heterosexual male character. When Deniz was the homosexual male in the scenario, 12.9 % females and 19.4 % males would avoid seeing him. The finding that male respondents discriminate against HIV positive female characters less than HIV positive male characters is quite matching with the experiences of Pervin and Leyla who provided information during the interviews that they did not face much discrimination from men.

2. **Would you worry that you may have contracted this virus because of working in the same environment with Deniz?** If Deniz was the loyal female character, 55.6% females and 60.9% males would worry. If Deniz

[59] As explained previously, all of the discriminatory ratings of each respondent were summed up and the last total number formed the *discrimination index* to be able to statistically analyze.

was promiscuous female, 51.6% females, and 50% males would worry. If Deniz was heterosexual male, then 37% females and 59% males, and if Deniz was homosexual male, 51.6% females and 52.8% males would worry that they have contracted the virus. It is again interesting that the females would worry the least (37% females) when Deniz was heterosexual male in the scenario. The rest of the responses are more or less the same indicating that this response is basically demonstrating the lack of knowledge of the respondents, and possible discriminatory attitude due to the fear.

3. **Would you think that Deniz contracted this virus due to his/her inappropriate behavior?** If Deniz was loyal female, 13.9% of females and 34.8% of males would think that Deniz contracted this virus due to her inappropriate behavior. If Deniz was promiscuous female, these numbers increased immensely as 87.1% females and 64.3% males said "yes". This percentage dropped for females (63%) and increased for males (76.9%) when Deniz was male heterosexual, and increased for both sexes (77.4% females and 86.1% males) when Deniz was homosexual.

4. **Would you warn people in the office environment telling that Deniz is HIV positive?** This is quite an interesting question since Deniz in the story particularly asked his/her friend to keep his/her HIV status as a secret. And yet, 8.8% of females and 34.8% of males said they would warn the other people in the office, if Deniz was the loyal female in the scenario. This number for females went up over four times (35.5 %) and somehow dropped for males (24.1%) when Deniz was the promiscuous female. This finding received from the female respondents shows that they would warn others in the office environment is very similar to the experiences of Leyla when her boss started phoning people and telling that Leyla had AIDS. Interestingly, 35.7 % of females and 43.6% of males would warn the co-workers, if Deniz was the heterosexual male, indicating that males would discriminate a heterosexual male, more than females. If Deniz was the homosexual male character, then 19.4% females and 25% males would warn the others. These percentages towards the homosexual male are lower than towards the

heterosexual male, almost indicating a protective attitude towards the male homosexual.

5. **Would you think that Deniz had an inappropriate sexual life?** If Deniz was loyal female in the scenario, 16.7% females and 30.4% males said "yes" to this question. It is surprising though since Deniz only followed the normal values in the society. If Deniz was promiscuous female, these numbers increased significantly, 71% females, and 65.5% males said "yes". If Deniz was heterosexual male, then 57.1% females and 79.5% males, and if Deniz was homosexual male, 77.4% females and 86.1% males would think that Deniz had an inappropriate sexual life. This question is very similar to the question 3 aboveand the responses given are very close.

6. **Would you think that Deniz deserved this virus?** If Deniz was loyal female in the scenario, none of the females and only 4.3% males said "yes" to this question. If Deniz was promiscuous female in the scenario, 9.7% females and 37.9% males said "yes" in this case. These numbers indicate almost 9 times increase for the number of females and males who think Deniz deserved this virus due to her sexual behavior. However, these percentages slightly decrease for both sexes when Deniz is the heterosexual male (7.1% females and 31.6% males), and increase again when Deniz is homosexual male (19.4% females and 44.4% males).

The results obtained from all of the questions regarding discrimination are provided in Appendix B.

5.2.8. Overall Discrimination Index Findings

The previous section provided some examples on how the respondents answered the questions differently depending on their perceptions of Deniz' sexual behavior. The total discriminatory score (sum of the 10 questions) of each respondent and the corresponding table and figures are shown below (see Appendix D for survey questionnaires).

Table 1: The frequency table for the discrimination ratings of the respondents

DISCRIMINATION INDEX

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 None	15	5.9	5.9	5.9
	1	35	13.8	13.8	19.8
	2	38	15.0	15.0	34.8
	3	53	20.9	20.9	55.7
	4	45	17.8	17.8	73.5
	5 Middle	28	11.1	11.1	84.6
	6	24	9.5	9.5	94.1
	7	7	2.8	2.8	96.8
	8	4	1.6	1.6	98.4
	9	1	.4	.4	98.8
	10 High	3	1.2	1.2	100.0
	Total	253	100.0	100.0	

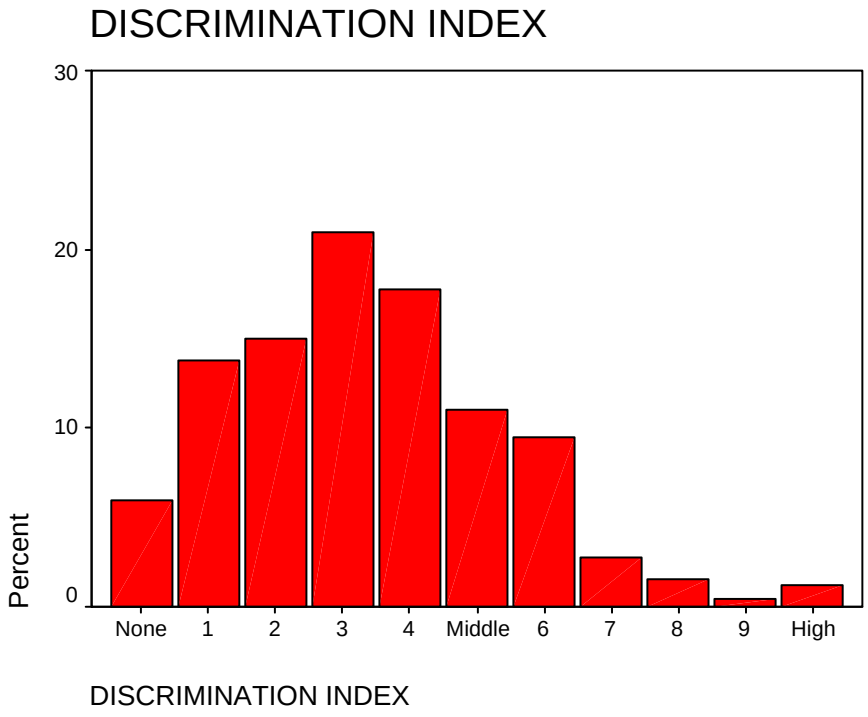

Figure 5: Discrimination Index for all Respondents

5.2.9. Changes in Discrimination Based on Sexual Norms

A one-way Analysis of Variance Test (ANOVA)[60] was used to examine the difference in discrimination ratings of the respondents towards the four different Deniz in the scenarios and the findings are presented in the next section. Overall, the respondents discriminated the loyal female significantly less than any of the other three characters ($p<0.05$)[61] (See the figures in Appendix B, for ANOVA and T-test results). The following figure demonstrates the discrimination index ratings against four different characters.

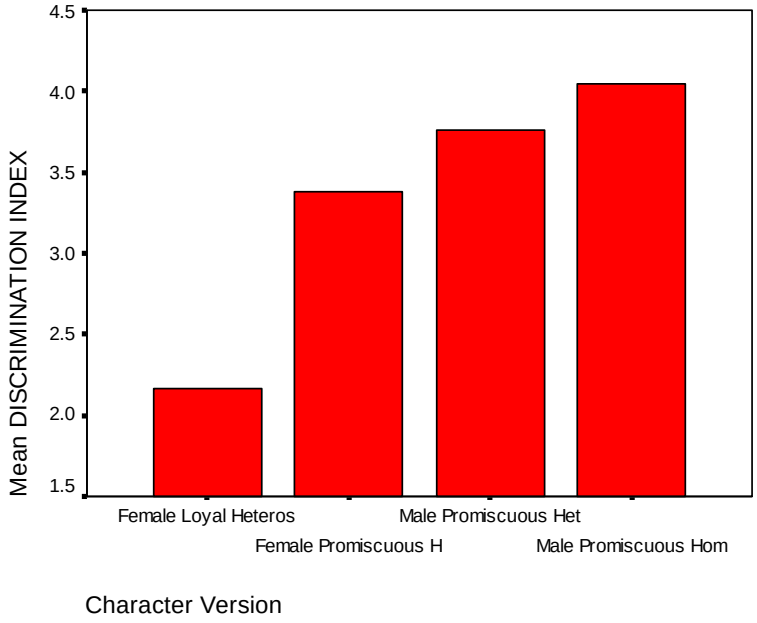

Figure 6: Overall discrimination index ratings against the four characters.

The results showed that the woman who followed the sexual norms was discriminated the least and this finding supported one of the predictions of the study which was *loyalty to a monogamous marriage for women would determine the amount of HIV-related discrimination*.

[60] Different statistical tests help the researchers use probability (p) to decide whether the differences between groups are due to chance. One of these tests is Analysis of Variance, known as ANOVA, which helps to look at the difference among three or more groups. Another test utilized is the t-test which tests the difference between two groups. In both tests, there has to be a hypothesis either to prove or disprove. The probability level used is generally $p<0.05$, meaning that the probability of the difference between groups that can be attributed to chance is below 5%, in other words the researcher can evaluate the results within 95% confidence level (Cozby, 1992).

[61] The significance level found was $p<0.005$, indicating that the confidence level is %99.5. In other words, the probability of this difference occurring due to chance is % 0.5.

If we compare the above result with the findings received from the interviews with men and women living HIV, we see that these findings are supportive of each other. Leyla, the 'loyal female interviewee', perceived less discrimination in general, and she almost escaped HIV-related stigma and discrimination due to her accepted sexual behavior. She followed the gender norms of the culture within the patriarchal structure of the society, and thus it wasn't her fault to contract this virus. This finding was especially obvious when her family, including her father, provided a lot of support to her. Tayfun, 'the promiscuous heterosexual male interviewee', also received support from family and friends. He followed the gender norms of the culture, had his sexual freedom, however, "accidentally" contracted the virus.

These findings also provide support to the findings of the research conducted in Africa that there is a relationship between the appropriateness of sexual norms and the level of HIV-related discrimination against women (ICRW, 2005). Researchers modeled this in a "Guilt Innocence" continuum demonstrating that women's sexual behavior is a determinant for the discrimination she faces (See Figure A3 in Appendix A). Other research also provides support that sexuality is seen as a strong determination for HIV-related stigma and discrimination, and that woman's sexuality is perceived differently than that of man's (Aggleton and Parker, 2003; Bharat and Aggleton, 1999).

Attributing HIV-related stigma and discrimination to sexuality displays several issues with respect to control of women's sexuality. Stigmatization and discrimination becomes a strong control tool for the society against women. Women, feeling this pressure, either learn to avoid the unapproved behaviors, or hide their unwanted behaviors in the fear of being stigmatized and discriminated. For example, loyalty is a highly held value in the Turkish culture for women and virginity is an indicator for girls for holding their virtue. Women who don't follow this constructed norm may try to hide their behaviors to escape from stigma and discrimination.

Goffman (1963) explained this phenomenon such that when the ones who stigmatize involve in discriminatory behaviors, those who are stigmatized may get involved in

such behaviors to get rid of the stigmatizing symbols. Authors discuss that women, who are expected to keep their virtue but didn't, may be pushed into getting virginity operations for avoiding stigmatization and discrimination (Cindoğlu, 2000; Mernissi, 2000). The importance of virtue for girls in Turkish society was also demonstrated by the high number of virginity tests that the doctors had conducted in Turkey in 1999 (Frank et al, 1999).

Therefore, as virginity becomes an indicator for virtue and loyalty, so does HIV. Pervin said that she would have preferred getting pregnant since she could have had an abortion which would have been the solution of the problem.[62] HIV then stands as a "stigma symbol", and gender becomes means to exert pressure over the "others" within the patriarchal society. Thus if a woman is loyal, keeps her virtue and has no control over contracting HIV, then she will not be blamed and discriminated due to her sexual behavior in the Turkish society.

One of the other predictions of the study was that *HIV positive women and men who follow the normalized sexuality (sexuality within marriage for women, and sexual freedom for men in heterosexual context) will be discriminated differently than those who are "deviant" (i.e., sexuality out-of-wedlock for women and homosexual orientation for men)*. Support for this finding is important with respect to examining the "normalized sexuality" as a moderator in Turkey.

5.2.10. HIV-Related Discrimination and Normalized Sexuality

As discussed previously, a model was built by dividing people based on their displayed sexual behaviors, that is one man and one woman are exhibiting "normal" and one man and one woman are exhibiting "deviant" behaviors (see Figure 2 above). A t-test was utilized for the comparison of the differences in discrimination ratings between the "normal sexuality" and the "deviant sexuality" group. This test showed that there was a significant difference and that the overall group of respondents discriminated the HIV positive woman and HIV positive man in the

[62] Women, who are forced to keep their virtue go through difficult procedures, such as getting virginity operations before their wedding night (Cindoğlu, 2000; Mernissi, 2000).

normal sexuality group less than the others in the deviant sexuality group ($p<0.005$).[63] The means for the normalized sexuality are shown below.

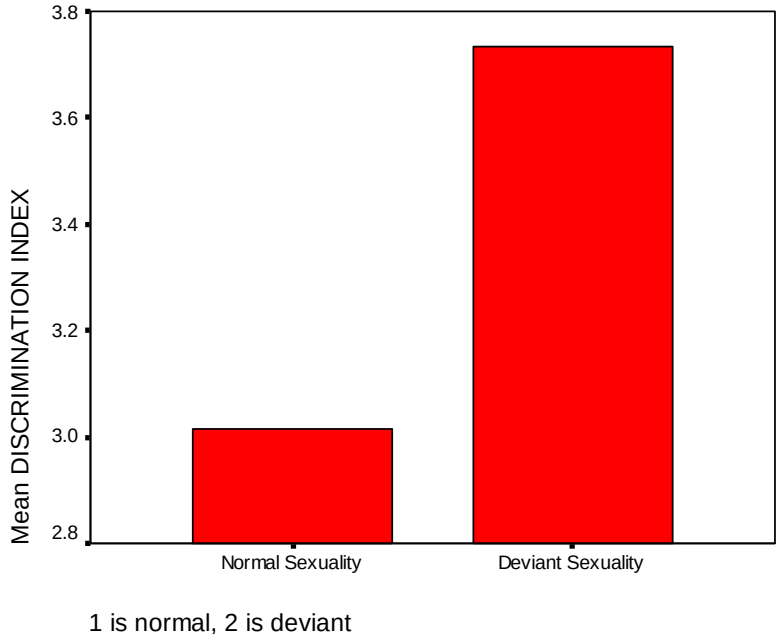

Figure 7: Mean discrimination ratings for all respondents with respect to normalized sexuality.

Thus, *the result provided support for the "normalized sexuality" prediction*. This result was also supported with the findings obtained from the interviews that women's sexuality out-of-wedlock was not approved by family, and men's sexuality out-of-wedlock did not seem to be an important issue within the HIV-related stigma and discrimination picture.

However, the results somehow are conflicting that the woman who contracted HIV out-of-wedlock (Pervin) did not face much discrimination from friends, from her boyfriend and her employer, as predicted. Also, the homosexual male interviewed (Arman) was not discriminated by his sister and brother, or any of his friends that he

[63] The "normal sexuality" group had a mean discrimination rating of 3.02 and the "deviant sexuality" had a mean discrimination rating of 3.73. A two-tailed t-test (shown in Appendix B) demonstrated that the discriminative ratings of the respondents towards normal and deviant groups significantly differed. The significance level found was $p<0.005$, indicating that the confidence level is %99.5. In other words, the probability of this difference occurring due to chance is % 0.5.

had revealed his status to. Therefore, is there another factor that is influencing the results which wasn't predicted at the beginning of the study? Is 'normalized sexuality' a valid concept for both men and women? To explore this, I decided to examine the data received from the female and male respondents separately.

5.2.11. Differences in Discrimination Ratings of Female and Male Respondents

When I looked at the distribution of the overall discrimination scores (i.e., the discrimination index ratings) of the female and male respondents, I found that they somehow differ as shown in the following figure:

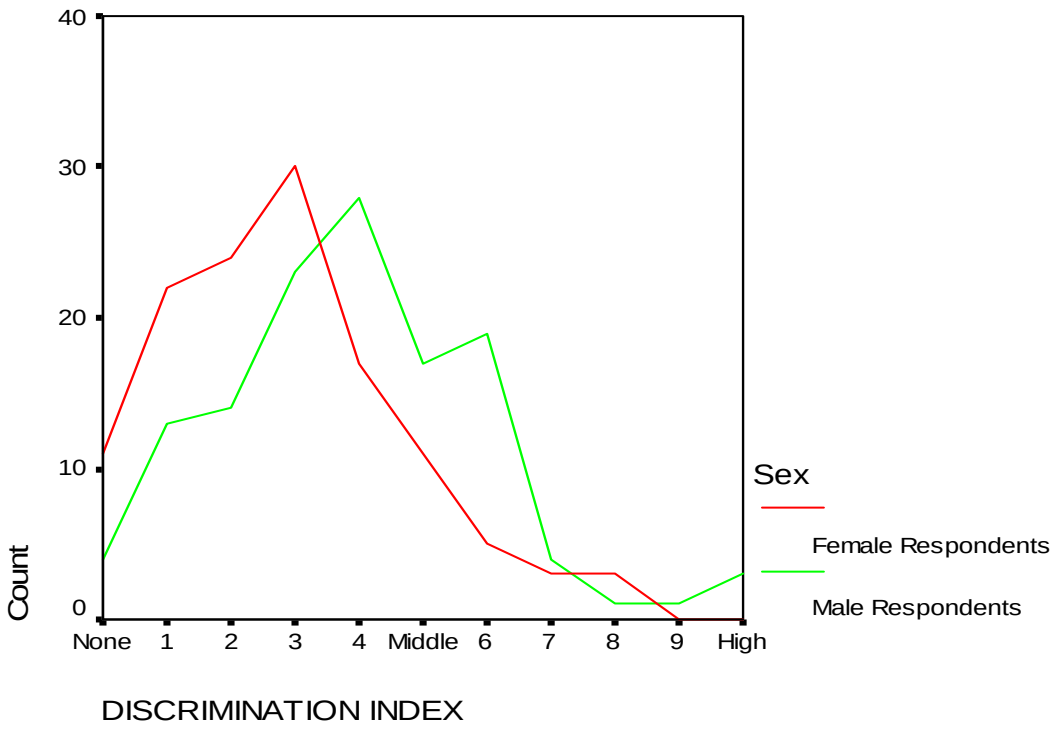

Figure 8: Discrimination Indices for Female and Male Respondents

This shows that the discrimination scores for the female respondents are less than the discrimination scores for the male respondents. I was then curious if there would be a difference between the ratings of male and female respondents towards the four different characters, and whether the normalized sexuality is a moderating factor for both male and female respondents. The discrimination ratings given by the male and

female respondents towards four different characters in the scenario seemed to be different, and this is shown in the following figure.

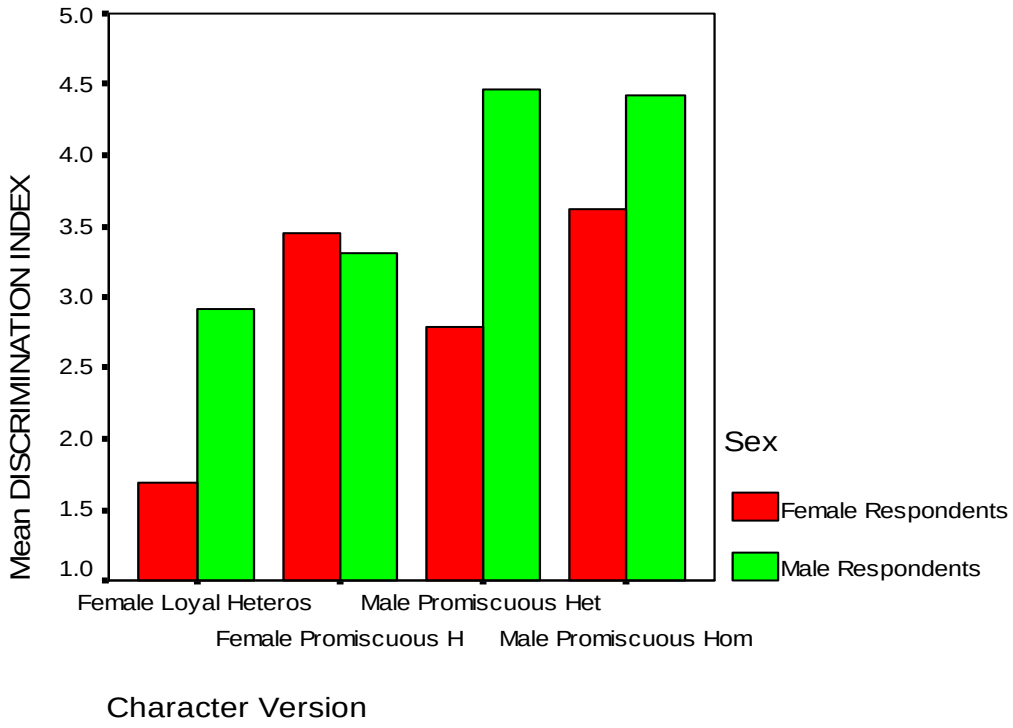

Figure 9: Discrimination ratings against the four characters for female and male respondents.

As shown in the graph above, (1) *the female respondents discriminated the loyal female and the male heterosexual less than female promiscous and male homosexual.* This result follows the normalized sexuality prediction, whereas (2) *the male respondents discriminated both of the HIV positive female characters less than both of the HIV positive male characters*. Thus the male respondents did not follow the prediction for the normalized sexuality and seem to discriminate on the basis of the sex of the HIV positive person. Were these differences significant? In other words: (1) Do the *female respondents* change their discriminatory behavior *based on the sexual behavior of individuals*? (2) Do the *male respondents* change their discriminatory behavior *based on the sex of the individuals*?

These differences were tested and the results are provided in the following sections.

A. Discriminatory Behavior of Female Respondents

A t-test was utilized to compare if the females discriminated the loyal female and heterosexual male in the "*normal sexuality group*" differently than the promiscuous female and the homosexual male in the "*deviant sexuality group*". The mean ratings of the females were *2.17* for the normal group and *3.53* for the deviant group and the difference between the groups was found significant ($p<0.000$). The results shown in the figure below indicated that female respondents discriminated against people living with HIV based on the "normalized sexuality", in other words based on the accepted sexual norms of the society.

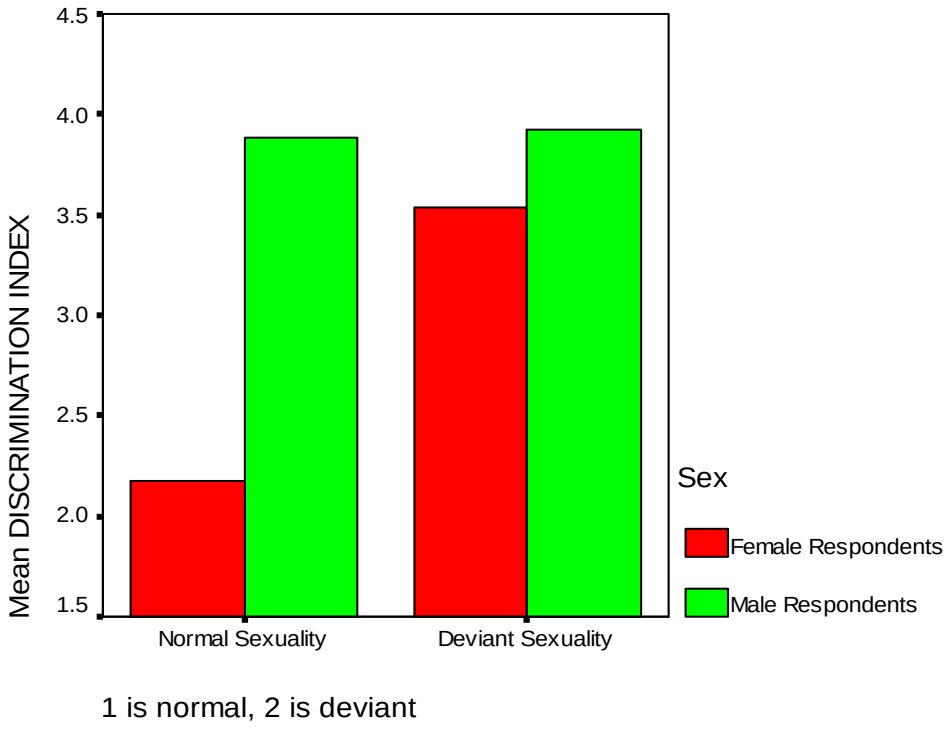

Figure 10: Discrimination ratings of male and female respondents based on normalized sexuality.

B. Discriminatory Behavior of Male Respondents

A t-test conducted on the data obtained from the male respondent showed that *the discriminatory responses of males did not change based on normalized sexuality*. In

other words, male respondents did not discriminate loyal female and heterosexual male any differently than the promiscuous female and the homosexual male.[64]

Is normalized sexuality then a constructed value in the society only for girls to keep their virtue? Therefore, would it be possible that males in Turkey would discriminate against women less than they would discriminate men? And how would this be for the female respondents?

To explore these questions above, two groups were formed for analyzing the data (i.e., groups based on sex, not the sexual behavior). The loyal heterosexual female and promiscuous heterosexual female (Characters 1 and 2) were grouped together as the "female HIV positive" characters, and promiscuous heterosexual male and promiscuous homosexual male (Characters 3 and 4) were grouped together as the "male HIV positive" characters. This is demonstrated in the following model:

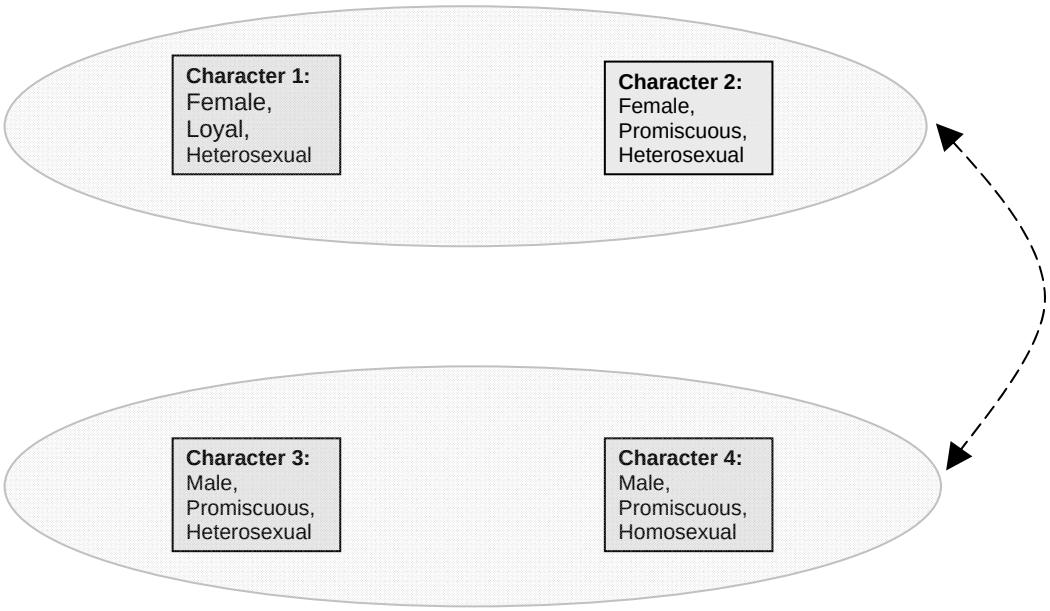

Figure 11: Discrimination model based on the sex of the character living with HIV.

[64] The mean ratings of the male respondents were 3.89 for the normal sexuality group and 3.92 for the deviant sexuality group. These numbers were almost the same and did not show any significant difference.

The results of analyzing the data on the basis of the sex of the character are provided in the figure below.

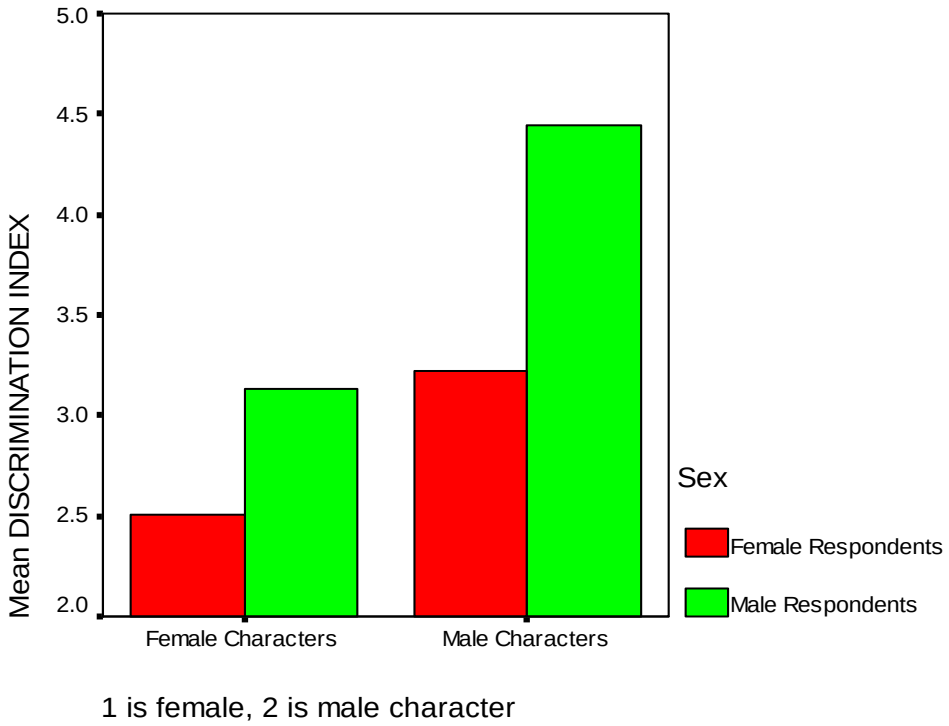

Figure 12: Discrimination of female and male respondents based on the sex of the character living with HIV.

As in shown in Figure 12 above, perhaps somewhat surprisingly, male respondents gave higher discriminatory ratings to the two HIV positive male characters in the scenario, and somewhat lower discriminatory ratings to the two female HIV positive characters.

Figure 12 provides strong support for the postulation that the male respondents discriminated against HIV positive females significantly less (3.13) than against HIV positive males (4.44) ($p<0.000$) as shown in Appendix B.[65] This finding was also supported with the qualitative data that the HIV positive homosexual man received support and care from doctors, friends and family. However, this finding was not

[65] A two-tailed t-test analysis demonstrated that the difference between the mean discrimination rating against HIV positive females (3.13) was significantly less than HIV positive males (4.44) with a level of chance: ($p<0.000$)

found the same for female respondents. Although female respondents discriminated somewhat less against female characters, the results are not statistically significant.[66] So then, what is happening?

5.2.12. A Summary of Qualitative and Quantitative Findings: Is 'Normalized Sexuality' a Norm for Women Only?

Before I started this study, I was expecting that a loyal female and a promiscuous male heterosexual would somehow be discriminated differently, since they follow the sexual norms of the Turkish society. People who do not follow these norms, such as promiscuous females and homosexual males would be discriminated at a higher degree. However, I did not predict that the normalized sexuality would be a norm to follow only for women and not for men (I somehow thought that this norm would be the same for everybody in the society).[67] It was also not obvious how patriarchy manifests itself as in the form of "protector of honour or as transgressor of women's body (i.e. gender relations)", as Ertürk explains (2004a:7).

In the Turkish society, girls are taught that men can have sexual freedom, and this behavior of men is normalized by the culture. Thus it can be expected that a heterosexual men with promiscuous behavior may not be discriminated due to his sexual behavior in the culture. Sexual freedom is not for girls, trust with the mother is built on virtue, and honor of the family is carried out through the woman's body. Meanwhile, boys don't learn the sense of control for their sexuality when they are growing up. The gender norms are designed to control the sexuality of girls and women but not those of boys and men. Girls in the culture are raised to hold good values and virtue in the Turkish society. This explanation has been discussed by

[66] The average rating of the female respondents was 2.51 for "HIV positive females" and 3.22 for "HIV positive males". A two tailed t-test analysis of the female sample population showed that there was no significant difference in the discriminatory ratings of females against males versus females (see the figures in Appendix B).

[67] This finding reminded me one of the sayings that my professor at the Simon Fraser University mentioned once: "*the rules are to be broken*". Who would break the rules of the society? The dominant groups in the society (sometimes the rule makers) always can break the rules and reconstruct other ones. Or do not follow the ones that they have already established while most of the rest of the society do follow them.

various authors (İlkkaracan, 1998; İlkkaracan and Seral, 2000; Cindoğlu, 2000; Marcus, 1992).

During the interviews, I obtained clues on how women perceived themselves when they had found out their HIV status, and this was shifted if the woman contracted HIV through a marital relationship, or out-of-wedlock. The families also behaved differently towards their daughters based on whether their daughters conformed to the sexual norms of the society. One woman (Pervin) punished herself as she felt that she misused her "mother's trust" by not keeping her virtue; she ran away from her family to keep the "family's honor" without telling her HIV status to her father. On the other hand, the woman who contracted the virus through her marital relationship (Leyla) felt sorry for the father since her marriage was arranged by her family. She was accepted and given a great deal of support by her family.

For the interviewed HIV positive men, the heterosexuality and homosexuality of men seemed to influence their perceptions of themselves in relation with HIV. The heterosexual man tried to show his "strength" against HIV, shared his status with his family immediately, and showed "anger" to his doctor. He later stayed at his home for a long time and took a break from his sexual life, which may indicate that his power was taken away with HIV. On the other hand, the homosexual man "blamed" himself, but showed "trust" to his doctor. He took responsibility for the "honor of his family", tried to keep his HIV status as a secret from most of his family and started making plans for running away from his home and waiting to die in a hotel room. Later, he shared it with only his brother and sister, while also revealing his homosexual orientation. The behavior of these men and women indicate that the acceptability of sexual norms in the society influences their thinking processes, behaviors and attitudes. The quantitative findings of the study provided support to these findings in the sense that a loyal positive married woman was discriminated significantly less than any of the other characters (promiscuous woman, heterosexual man, homosexual man), and that she expected protection and support from her family.

For keeping good values and virtue, there are various control mechanisms in the society for the girls. These control mechanisms, as observed during the interviews,

are embedded in the construction of gender, such as "being responsible for the honor of the family by holding a virtue for girls", "being protected by the male members of the family", "being open and honest with one's mother so that she can control her daughter", "desire to belong to the valued group and thus doing self-control" and "stigmatizing and discriminating the others who belong to the devalued group". Gender, by providing clear divisions among its members, ensures that the girls stay as girls and boys stay as boys, in order to sustain the existing patriarchal power structures in the society.

Being responsible for the honor of the family gives a strong burden to the girl, thus controls her. As observed in the interview, Pervin felt terrible for causing such a problem to her family, especially to her father and brother, the male members of her family. Leyla, on the other hand, did not even think about the honor of the family, for her, contracting HIV brought a disaster to the family, including herself. It seems clear that a control mechanism is in place.

Being protected by the male members of the family is quite an interesting control mechanism for women. Within the gender construction in Turkish society, "women are weak and need protection" and "men are strong and they are to protect women". What boys learn when they grow up is "protecting the girls". Boys assume this responsibility very strongly; for example they accompany girls at nights on streets for protection, get involved in fights if a girl friend of theirs is harassed by other boys, etc. Thus, their fundamental belief is that "women are to be protected and cared for". Besides, they fundamentally learn that men have to show strength and this is one way of "being a man". The fights being engaged for women also prove their strength and keep their status in the society at a higher level in the patriarchal societal structure. The power is then sustained within the males.

However, man having authority also means he holds power over the women, which has the potential to be abused. The male "guardian" is responsible for the female members of the family, and this can involve punishing them if they are disobedient. For example, Pervin lived protected in a house, as long as she kept her virtue, but she was worried about violence from her father after she had found out her HIV positive

status out-of-wedlock. Leyla didn't even consider facing violence from her father because she obeyed the rules of her family, which reflects the rules of the patriarchal structure of the society. Various authors also provide similar finding that in some cases, the woman is exposed to violence upon being found out that she is HIV positive (e.g., APN+, 2004; ICRW, 2005; Ertürk, 2005).

Being open and honest to the people around appeared strongly in the case of HIV positive females, again indicating another control mechanism for keeping her virtue. Starting from childhood, girls learn to be honest, to be open, and tell everything to their mothers and friends. If they accidentally do not follow the rules, than they are put on track by their mothers. This was shown strongly in the interviews that HIV positive women both had a need to tell it to the people who were close to them, for example their mothers, bosses, and friends; even though they felt that there was a risk of being stigmatized and discriminated whereas boys don't learn to be open to the family in the culture.

One strong self-control mechanism in the society is stigmatizing and discriminating the "other". Girls are taught to judge and discriminate against promiscuous girls who do not belong to the "proper" group. In other words, the judgmental behavior is given as a tool to the girls to provide "self-control" to sustain their virtue. The girl then creates a division between the "proper" (herself) and "improper" (the other) and learns to discriminate others as a self-control mechanism. Girls are then rewarded by marriages (with wedding ceremonies focusing on purity) in a heterosexual context if they keep their virtue and are expected to stay loyal to their husbands. As people use stigmas to create a division in societies as "us" versus "them" (Gilmore and Somerville, 1994), the "promiscuity" becomes quite a heavy burden for a girl to hold in the Turkish culture. Thus, holding one's virtue becomes a valued norm for girls. Lorde (1984) mentions that each of the attributes of a valued category sets a foundation for oppressing the "other" who is not the members of this valued group. This can explain why female respondents discriminated the promiscuous female character in the scenario. In female respondents' case, quantitative data showed that female respondents discriminated HIV positive women more than male respondents. This again indicates the underlying belief of the female respondents that "women

should be loyal to their families, virtue is important" and there is a division between a "proper" and "improper" women, and this is a learned value for women to follow as a self-control mechanism. In this case with respect to gender and HIV-related stigma and discrimination, virtue is a valued category, whereas promiscuity is a devalued category, and promiscuous women are placed in the devalued category by female respondents. The female respondents in the study may have put a border between her and the "other", the female character in the scenario.

For men, the explanation of sexuality may be quite different based on gender. The boys, when they are growing up, are given sexual freedom and encouraged to experience sexuality before they get married (e.g., the existence of brothel houses in Turkey and men in the family encouraging boys to have sex before marriage is quite common in the culture). Boys are not given the same sense of self-control for sexuality as girls are, so they may not actually learn to judge and discriminate other men based on their sexual freedom. Thus they may not learn to discriminate men differently, based on the assumption that each man has a sexual freedom. This may explain why male respondents did not discriminate homosexual and heterosexual male HIV positives any differently in the study.

Also, qualitative findings provide support to the quantitative findings for sexual freedom for men. Sexual freedom is a given right to men in the culture. For example, Tayfun did not hide his sexuality when he revealed his HIV status to people around him at the time he learned his HIV positive status. Arman said that he first revealed his HIV status to his sister and brother, and then mentioned his homosexual orientation in between his words, possibly trying not to highlight that aspect too much. One of the quotes from Leyla can provide support for this discussion:

> *Men who are homosexual may have to get married to prove their manhood to their families. Then, they have to have children, as that's what their families expect from them. Most families realize that he has a second life outside of the house, but as long as he continues to follow the norms, he can continue his life like that, and not many people interfere.*

This may mean that as long as a man, with homosexual orientation, gets married with a woman and follows the rules of the society, he may be discriminated at a lesser degree. However, it is suggested that this may be a suitable area for further studies to be performed.

With respect to discrimination against HIV positive women, why did Pervin's male boss not discriminate Pervin who had contracted HIV out-of-wedlock? Again, why did Leyla's male boss not discriminate Leyla (please note that she was divorced at the time she had revealed her status)? The male bosses provided support to both of the women regardless of their sexuality within or out-of-wedlock, but a female boss showed a discriminatory attitude to one of the women (to Leyla, who contracted the virus through wedlock but who was separated from her husband at the time the boss discriminated her). Similarly, both women interviewed told that after they learned their status, they later met boy friends who were both HIV negative. Both have been accepted by the boyfriends, and the woman who contracted HIV out-of-wedlock got married to her boyfriend. This finding was also supported with the quantitative findings that male respondents discriminated HIV positive women less than they discriminated HIV positive men.

One explanation for the above findings can be that this is due to men's protective attitude within their gender construction in the Turkish society. The men are the guardians of women (as explained previously, if the woman had contracted HIV, it is the man's failure since he couldn't protect the woman). An interesting phenomenon that occurred in Turkey can be given as an example here: International Organization of Migration (IOM) recently opened a hotline in Turkey for saving trafficked women. The operators were quite surprised to receive a number of calls from Turkish men asking assistance to save the woman they met from the trafficker's hands. There may be couple of explanations for this behavior. One can be attributed to the protective role of the man; when the man sees that the woman (who he first thinks is a "prostitute") is actually not prostituting herself but she is helpless, slaved, needs help and protection, man's strong protective attitude appears to save this woman. "Sexuality is for men" so he sees this woman to be saved for. Gülçür and İlkkaracan (2002) also found a parallel finding when they interviewed a migrant sex

worker. The woman, from Kazakhstan, was working in the sex trade when she met her Turkish boyfriend in Turkey. The boyfriend wanted to care for her and marry her and told her to quit her job. The boyfriend's family and friends knew about her and accepted her, as she described. Here, we can again see a caring attitude towards the woman who needs protection. A similar finding was found during the qualitative interview with Arman in that a woman who is in the sex trade is sympathized by the society because she has fallen into that life, and that it is not her fault. (Gülçür and İlkkaracan, 2002).

The protective behavior of men leads to the discussion that in the patriarchal culture, women are as assets, and they are to be cared for. Therefore, the difference between men's discriminatory attitude against HIV positive women and men can be explained with the following logic: if men feel responsible for women, and if they are the guardians of women, then men have to protect women. If sex is based on man's choice, and if a woman contracts HIV, then the man must have failed to protect the woman (i.e., had unprotected sex) and transmitted the virus to the woman in the scenario. It appears that it is the men blame other men for not being able to care for women, care for their commodities. Ironically, behind the caring behavior of men, it shows how women's status is subordinate in the society, how sexuality of women is controlled and how there is gender inequality existing within the patriarchal power structure.

In summary, throughout the study, I have argued that there are various control mechanisms around women's sexuality. These are at different levels, and are sustained through various means as described below:

Level 1: Self-control

Through socialization, women internalize sexual norms by which they exercise self-control over sexuality to avoid being stigmatized and discriminated. From childhood, girls are told that girls who keep their virtue belong to the "valued group" and the ones who don't belong to the "devalued group".

Level 2: Family control

If women do not behave in conformity to the sexual norms, then they are penalized by the family such that they are rejected. In this case:

a. Protection becomes a positive reinforcement for girls to keep the norms and values in place. If girls fail to belong to the valued group, then they may have the risk of losing protection provided by the father now, or by the husband in the future.
b. Violence becomes a negative reinforcement for girls such that they face violence particularly by the male members of the family.

Level 3: Community control

Women who deviate from social norms and values of the community are then penalized by the community such that they are excluded and discriminated.

Level 4: Legislative Control

Governmental legislation gives the power to the authorities to control women's sexuality, such as allowing virginity tests or dismissing girls from school upon disclosure of their engagement in sexual behavior.

The figure below summarizes these levels and control mechanisms built around women. As shown in the figure, these mechanisms surround the woman, one strengthening the other to keep the woman strongly under control. The control mechanisms are interactive, supportive to one another but not static. These mechanisms can be punctured by various efforts, such as women's individual and collective resistance, women's transnational movements, engagement with international gender equality regimes, etc. These lead to paradigm shifts where woman's control over her sexuality increases and patriarchy is re-configured. It is suggested that further research can explore both the sustainability of these mechanisms and their potential for change.

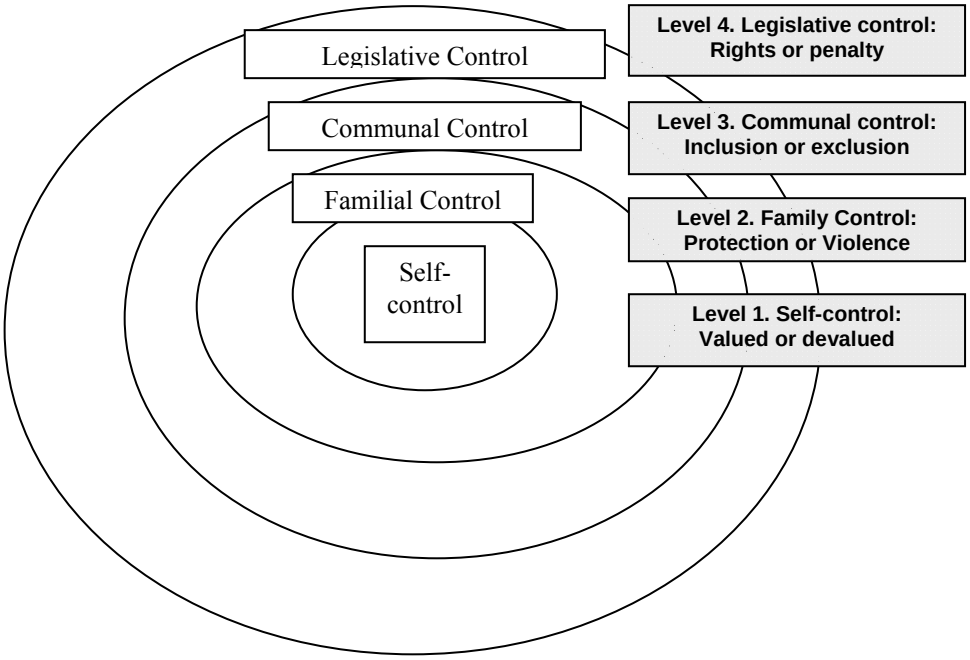

Figure 13: Control Mechanisms around Women's Sexuality

This model does not necessarily explain the societal control over male sexuality. Boys grow up with a sense of sexual freedom and are encouraged to experience sexuality before they get married (e.g., the existence of brothel houses in Turkey). Demonstration of manhood, i.e., being valued is in fact based on male sexual performance rather than abstinence. Therefore, the sexual control mechanisms around men operate through sexual promiscuity. This may involve men to exert pressure on other men to live up to such notions of manhood. The control mechanisms around sexuality provide a potential area for further research.

5.3. Knowledge of the Respondents on HIV/AIDS

When respondents were asked how they rate their knowledge on HIV/AIDS, 44.9 % of the male respondents said they had adequate information whereas 27.2% of females said that they had adequate information on HIV/AIDS. More of the male respondents stated that they were adequately informed about HIV, compared to the female respondents, and yet the ignorance level of males and the ignorance level of females was not found to be significantly different. This indicates that males believed they had more information on HIV than they really did, compared to

females. Is this a gender trait for males to be overconfident? This is another topic of potential further research.

The results of some of the knowledge-based questions on HIV were interesting. Both females and males know that HIV does not transmit through sharing a phone, or shaking hands. However, 29% males and 21% females believe that one can contract HIV through coughing or sneezing. This finding provides support to the previous research that since HIV is transmissible, AIDS was misinterpreted to be transmitted like flu or tuberculosis (Herek and Glunt, 1988; Bharat and Aggleton, 1999; PANOS, 2001).

A large percentage of females (37.6%) and males (28%) believed that they can contract HIV by sharing the same toilet. Again, 27% females, and 33.6% males believed that sharing the same utensils is a route of transmission, and 57.7% females and 65.6% males believed that one can contract HIV through mosquito bites. Another interesting finding is that 48.2% females and 56.1% males did not know that HIV can be transmitted through breastfeeding. Almost all knew that HIV can be transmitted through unprotected sex. The sexual transmission characteristic of HIV is known the best among respondents which indicates that people living with HIV are more likely to be associated with sexual behaviors in the eyes of others. All of the answers are listed in the table below.

Table 2: Knowledge level of HIV for all respondents.

QUESTION	RESPONSE	Sex	
		1 Female	2 Male
Contracting by sharing a phone	0 Correct	98.4%	96.9%
	1 Wrong	1.6%	3.1%
Contracting by shaking hands	0 Correct	100.0%	98.4%
	1 Wrong	.0%	1.6%
Contracting by coughing and sneeze	0 Correct	78.7%	71.0%
	1 Wrong	21.3%	29.0%
Contracting by sharing toilet	0 Correct	62.4%	72.0%
	1 Wrong	37.6%	28.0%
Contracting by sharing utensils	0 Correct	73.0%	66.4%
	1 Wrong	27.0%	33.6%
HIV positives may not know their status	0 Correct	82.1%	87.2%
	1 Wrong	17.9%	12.8%
Contracting during pregnancy or at birth	0 Correct	93.4%	90.4%
	1 Wrong	6.6%	9.6%
Contracting by mosquitoes	0 Correct	42.3%	34.4%
	1 Wrong	57.7%	65.6%
Contracting by breast milk	0 Correct	51.8%	43.9%
	1 Wrong	48.2%	56.1%
Contracting by sharing a phone	0 Correct	97.6%	96.8%
	1 Wrong	2.4%	3.2%
Contracting by unprotected sex	0 Correct	98.4%	98.4%
	1 Wrong	1.6%	1.6%

The total score given to the incorrect answers formed the ignorance index and the index values ranged from 0 to 7 incorrect answers out of 11 questions. The distribution of scores is shown as below. Note that the scores between male and female respondents are quite similar indicating that the level of knowledge is similar.[68]

[68] As described previously, respondents answered a set of 11 "yes" and "no" questions measuring their information on HIV/AIDS. Each correct answer received a score of "0" and each incorrect answer received a score of "1". An "ignorance index" had been calculated for each respondent based on their responses to 11 questions related to basic information on HIV (e.g., does HIV transmit sharing the same phone, same toilet, etc.). The total score of each respondent formed the "ignorance index" for that person. The higher the scores were, the more ignorant the respondents were.

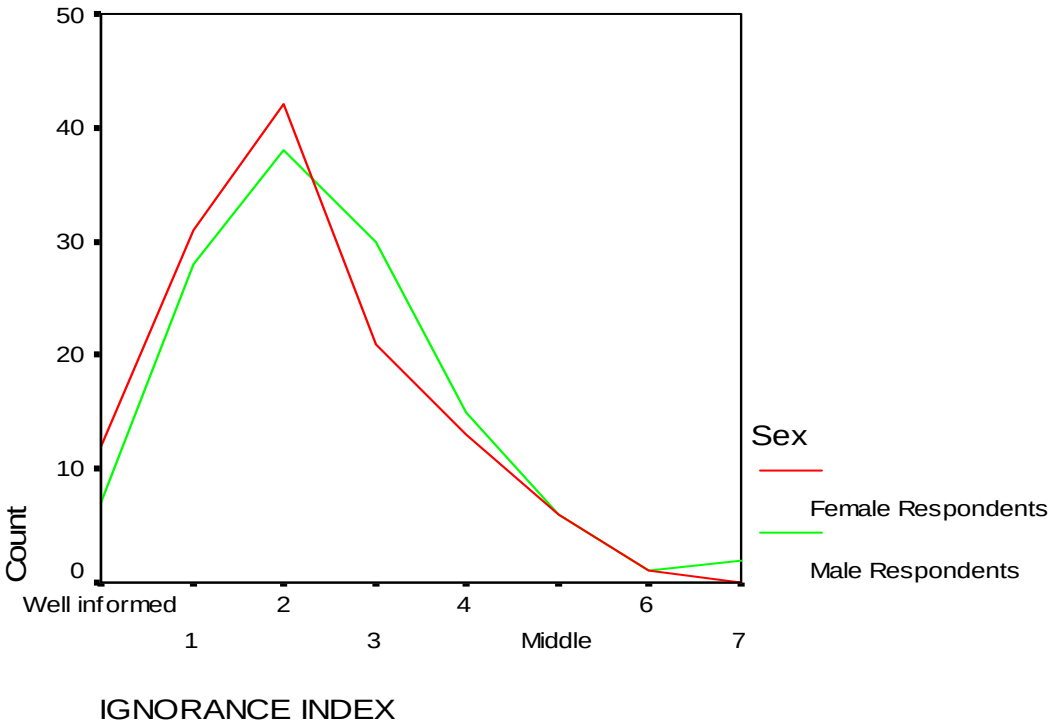

Figure 14: Graph showing number of questions answered incorrectly by male and female respondents.

5.3.1. Relationship between lack of knowledge and Discrimination

It was predicted that the less knowledgeable the respondents were, the more likely they would be to discriminate against an HIV positive. This prediction was tested with a correlation analysis.[69] A significant positive correlation was found among discriminatory responses and the level of ignorance (see the figures in Appendix B). In other words, we can say that less knowledge on HIV/AIDS leads to more discrimination against an HIV positive person. This is shown in the following figure.

[69] A correlation analysis was conducted between ignorance index and discrimination index and found to have a significant positive correlation between two values.

Table 3: Correlation between Ignorance and Discrimination.

		DISCRIMINATION INDEX	IGNORANCE INDEX
DISCRIMINATION INDEX	Pearson Correlation	1	.186(**)
	Sig. (2-tailed)	.	.003
	N	253	253
IIGNORANCE INDEX	Pearson Correlation	.186(**)	1
	Sig. (2-tailed)	.003	.
	N	253	253

** Correlation is significant at the 0.01 level (2-tailed).

This finding supports the previous research findings in other countries (e.g., Herek and Glunt, 1988; Bharat and Aggleton, 1999; PANOS, 2001) as well as in Turkey (Duyan and Duyan, 2004; Gelbal and Duyan, 2006). This indicates that the more knowledge people have on an issue, the less prejudices and thus discrimination they will have. The low level of knowledge assessed among the dental students also show that there is inadequate information and awareness on HIV/AIDS in the Turkish society, even among the members of the population who are expected to have accurate information and who are future dentists and that more education is needed.

5.3.2. Conservative Views of Respondents

As described previously, respondents answered a set of three questions indicating their conservatism on sexuality. The "conservatism index" had been calculated for each respondent based on their responses to 3 questions related to sexual acceptance of homosexual friends and liberal views on sexual lives.

5.3.3. Relationship between Conservative Views and Discrimination

It was predicted that the more conservative the respondents were, the more likely they are to discriminate against someone living with HIV. This prediction was tested using a correlation analysis (conservatism index versus discrimination index) and found to have a significant positive correlation, as shown in the figure below. It thus appears that people judge HIV positives using their conservative morals and thus discriminate more highly against a person living with HIV. This study also provides

support to the study where conservative values seemed to play a role in HIV-related discrimination (Greene and Banerjee, 2006).[70]

Table 4: Correlation between Conservatism and Discrimination.

		DISCRIMINATION INDEX	CONSERVATIVE INDEX
DISCRIMINATION INDEX	Pearson Correlation	1	.231(**)
	Sig. (2-tailed)	.	.000
	N	253	253
CONSERVATIVE INDEX	Pearson Correlation	.231(**)	1
	Sig. (2-tailed)	.000	.
	N	253	253

** Correlation is significant at the 0.01 level (2-tailed).

5.3.4. Relationship between Conservative Views and Ignorance

Note that the figure below shows that there is not a significant relationship between the ignorance index and the conservatism index.

Table 5: Table showing correlation between Conservatism and Ignorance

		CONSERVA-TIVE INDEX	IGNORANCE INDEX
CONSERVATIVE INDEX	Pearson Correlation	1	.026
	Sig. (2-tailed)	.	.679
	N	253	253
IGNORANCE INDEX	Pearson Correlation	.026	1
	Sig. (2-tailed)	.679	.
	N	253	253

[70] With respect to discrimination related to an immoral behavior, researchers explored if there is a correlation between the negative responses to homosexuality and cancer and if this would create the same stigmatic response, since it carries similar characteristics with AIDS. As expected, AIDS was found to create more stigmatizing responses than cancer and that negative attitudes toward homosexuality was related to negative attitudes towards AIDS but not people living with cancer (Greene and Banerjee, 2006).

CHAPTER 6

CONCLUSIONS

The qualitative and quantitative findings of the study overall demonstrated that gender has an impact on HIV-related stigma and discrimination, and that normalized sexuality acts as a moderating factor for female respondents. This study also demonstrated that sex of the person living with HIV is a determining factor in being discriminated against, especially for male respondents. Somehow surprisingly, the sexual orientation of HIV positive male characters was not found to be an influential factor on HIV-related stigma and discrimination.

This study indicated that gender identity norms influence the discriminatory attitude towards HIV positive males and females and that "men's sexual freedom" and "women's sexuality within wedlock" are the existing norms within the Turkish society.

Gender norms are not natural; their construction makes a clear division among two sexes in the society and provides guidelines on how each sex should be different. Gender is constructed starting from birth; members learn how to follow it, and then pass these rules onto the next generations and thus sustain the existing gender construction. The sustenance of gender norms is essential to keep the patriarchal power structures in place. If members of each group do not follow the expected gender division, they then are stigmatized and discriminated. Thus, stigmatization and discrimination are used as tools to reinforce the rules of the patriarchal society.

Within this patriarchal structure, the valued norms become tools of control. Control occurs such that a girl or a woman is reinforced to adopt this norm because having this attribute will make the woman belong to the "valued" group. Girls, as they grow up, learn to follow this norm because they desire to "belong to the valued group". The rewards for confirming the rules of the society are the continuity of her protection by the family or by the "husband" in the future, inclusion to the community and accessing to the rights in the society.

In this regard, the findings of the study show that women's attitudes towards sexuality are strongly influenced by the rules of the patriarchal structure. To avoid stigmatization and discrimination, women feel pressured to have a very high level of "self-control", and they have a strong need "to be open" to their family and friends more than men, and have the "fear of violence" in order to follow the rules of the patriarchal structure. In this sense, the HIV positive status of men, in a heterosexual context, can be accepted in an easier way by females since HIV positive status is attributed to "man's sexual freedom which is his right". Similarly, the HIV positive status of loyal women can be accepted by females since the HIV positive woman has conformed to the rules of the patriarchal structure, but still has contracted HIV. Women discriminate against other promiscuous women who did not follow the norms and who failed to keep their virtue. Thus HIV itself is not an indicator of either "obeying" or "disobeying" the sexual norms of the patriarchal society, it is the sexual behavior of how the HIV positive person contracted the infection. These findings demonstrate the hierarchies within the patriarchal power structures, namely, women discriminating women (class differences).

The findings of the study also demonstrate that men's discriminatory attitude towards people living with HIV are also strongly influenced by the gender identity construction. In the patriarchal society, freedom in sexuality is a privilege given to men. The Turkish society teaches boys to be "strong", and also to "protect the girls and women", who are actually men's valuable assets. The boy, who is strong, and who learns how to protect, assumes responsibility for a "virgin girl" within a marriage. However, if men already are given access to sexuality, they also need women to experience sexuality in a heterosexual context. In other words, men need

both “loyal” and “promiscuous” women in the society, so that they can both (i) experience freedom in sexuality and (ii) be rewarded with a virgin to marry to prove their strength and manhood. Therefore, they need to protect both of their assets. This may explain why men discriminated both the loyal and the promiscuous HIV positive women at a lesser degree than they discriminated men. It again also shows the hierarchical power structures (gender differences)-even though it is in the reverse form.

Men’s higher level of discrimination against HIV positive men can also be explained in the same manner. Men are expected to be strong, to care for women. If a man contracts HIV, his strength is threatened and man, being the guardians of women, has failed to protect his woman. Therefore, HIV shows his lack of strength, both for not being able to protect his woman and for not being able to continue his sexual freedom which is strongly associated with demonstrating his “manhood”.

In the light of discussions above, the normalized sexuality then appears to be a strong moderating factor for women, but not for men, in the Turkish society with respect to HIV-related stigma and discrimination. The normalized sexuality, women being loyal and holding their virtue, and men having sexual freedom out-of-wedlock, is taught in the society and it reflects itself strongly in females for HIV-related discrimination. Even though “loyalty” for women and “sexual freedom” for men are normalized in the Turkish culture, “the need for protection for women” and “protective attitude of men” seem to have a strong influence on HIV-related stigma and discrimination.

It is expected that the findings of this current study can contribute to the field of study in a number of ways. With this study, it is demonstrated that gender is an inseparable aspect for stigmatization and discrimination. The manifestations of patriarchal power structures can appear differently in each society. Analyzing the prevailing patriarchal norms and values can be a way of understanding the mechanisms that moderate HIV-related discrimination in cultures. It is thus suggested that patriarchy should be examined further for a better understanding of HIV-related stigma and discrimination.

While analyzing the role of patriarchal norms and values on HIV-related stigma and discrimination, it may be useful to utilize comparative and cross-cultural studies to understand the hidden effects of patriarchy. Because patriarchal norms and values may manifest themselves somehow differently based on the cultural context, stigma reduction programmes designed in one culture may not be successfully implemented in a different culture. We should consider that stigma is a complex social phenomenon that is interactive between the psychological and social matters of the stigmatized people and the social and economic factors in the society (ICRW, 2005).

People in positions of authority have the opportunity to challenge the existing stigmas and introduce new (desired) norms. Further research and advocacy are needed on women's sexuality and concepts such as "virginity", "virtue" and "loyalty" should be challenged at various platforms. Women's subordinate position must be carefully examined and plenty of messages in the culture through media must be delivered to make a paradigm shift. If the existing norms with respect to sexual behaviors of women and men can be freed from the existing power structures, then HIV-related discrimination will slowly disappear, since it is strongly attached to sexuality and gender. If the "sexual freedoms for men and women can be equalized" and sexuality education can be provided starting at an earlier age, there will be a chance to make a change in the existing control over women's sexuality in the society.

This study also showed that the level of knowledge influences the amount of discrimination against people living with HIV. Thus, it is also suggested that promoting knowledge on HIV/AIDS is a crucial factor. More accurate information on HIV transmission methods should be disseminated in public. While raising awareness, it should be noted that considering HIV only as a sexually transmitted infection perpetuates the stigmas that already exist in the societies. For example, for many years, the sexual route of transmission of HIV has been highlighted, and "abstinence and loyalty" have been suggested by many authorities to stop the transmission of HIV. These suggestions only perpetuate the existing stigmas that "HIV transmits through sexual contact and people who do not practice abstinence and who are not loyal contract the virus".

In addition to the conclusions and their relevant recommendations stated above, some recommendations are made for advocacy purposes:

Overall, we must promote the idea that "HIV" belongs to us, it is a human virus, and ignoring it will only help the virus spread. The medical school curriculums could include more information on the social aspects and gender dimensions of HIV so that prospective dentists, medical doctors, and nurses learn about HIV in a multidimensional manner to discover and confront their own stigmas and discrimination, and provide appropriate medical care and treatment to the patients, instead of judging them in moral terms. It may also be useful to hold discussions about stigma and discrimination with respect to sexuality at health-care settings by highlighting the existing power structures that shape "unwanted moral judgmental behaviors".

Prevention programs that focus only on marginalized populations (such as for sex workers or gay populations) and distributing condoms only to the marginalized populations reinforce to perpetuate the embedded stigmas. These kinds of interventions could only be successful if complimentary programmes are designed to tackle the issues of gender at all levels in the society.

Not allowing HIV/AIDS and sexuality education is an indicator of HIV-related discrimination and governments should be held accountable for discriminating their own citizens. This issue should be approached from a human rights perspective.

Additional insight to gender aspects of HIV-related stigma and discrimination could be provided by future studies on:

- Prevailing sexual norms in Turkey to understand the patriarchal power structures.
- Methods that are used to control the sexuality of women in Turkey.
- Various sexual behaviors and sexually transmitted infections to understand the relationship between discrimination and stigma and sexuality.
- Perceptions towards homosexuality in Turkey within the context of HIV/AIDS.

- Gender roles of homosexuals (e.g. holding the honor for the family and protective attitudes towards women).
- Relationship between ignorance, conservatism and discrimination to demonstrate the intersectional characteristics of various power structures, such as religion, race, etc.
- Knowledge, attitudes and behaviors towards condom use with a gender perspective.
- Notions of normalized sexuality in different societies (i.e., with cross-cultural and comparative studies).

When I started this study, my expectation was that I could help reduce stigma and discrimination against people living with HIV if I could understand the mechanisms behind HIV-related stigma and discrimination. I now have better understanding on how to spend our energies in the right areas towards changing knowledge, attitudes and behaviors of both men and women in our societies. Throughout my study, I have seen that reducing HIV-related stigma and discrimination is not possible unless we challenge the existing patriarchal power structure in societies. Patriarchal power structure, being universal, creating categories and hierarchies within, sustaining the power within itself and producing and reproducing more power, has appeared as one of the biggest challenges for reducing many kinds of stigmas and discrimination. As a last word, I have learned that norms can change and paradigms can shift if we work towards eliminating our own biases and stigmas.

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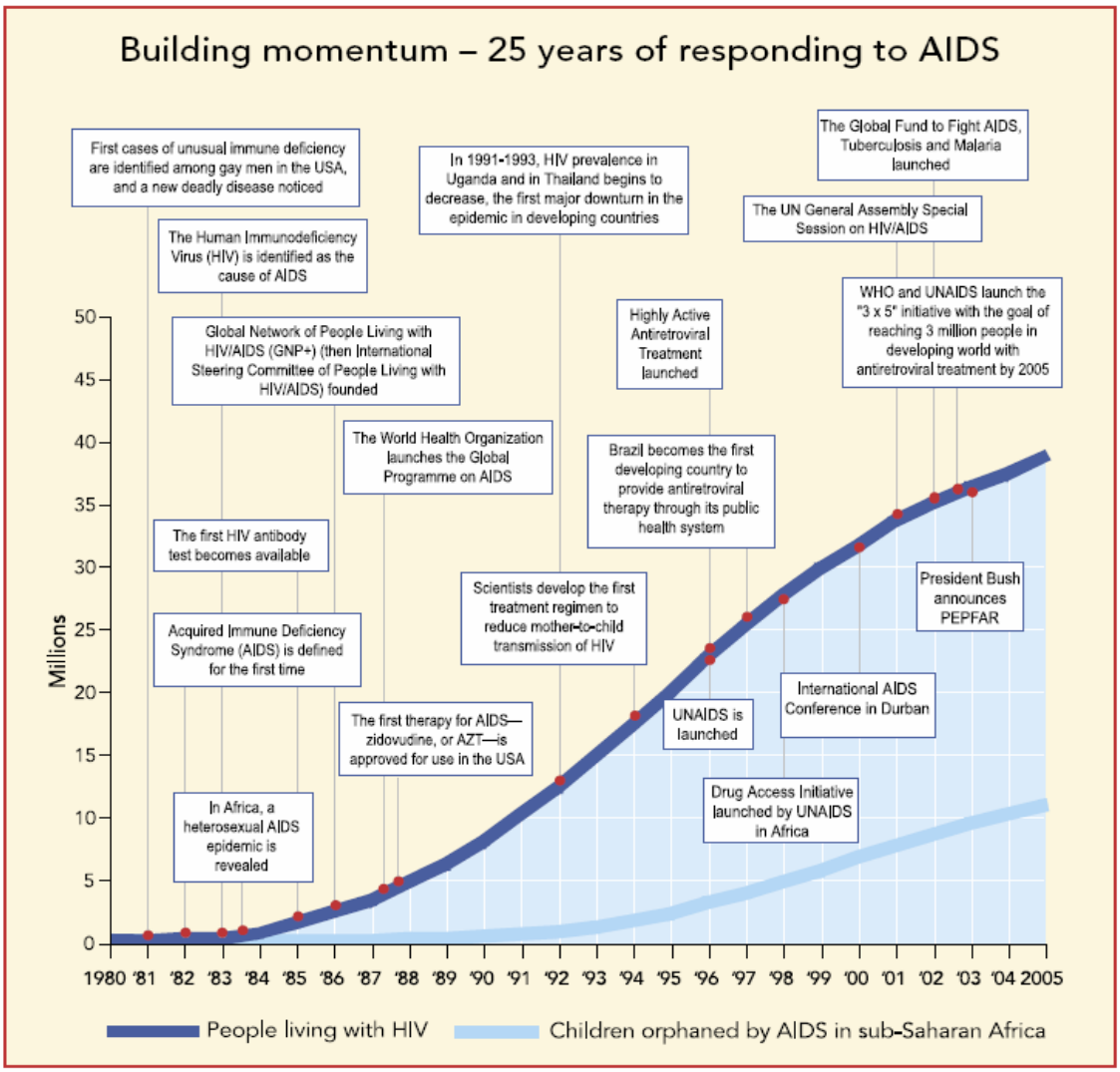
http://www.en.wikipedia.org
http://www.en.wikipedia.org/wiki/Perspective_(cognitive)

APPENDICES

APPENDIX A: HIV/AIDS INFORMATION FIGURES

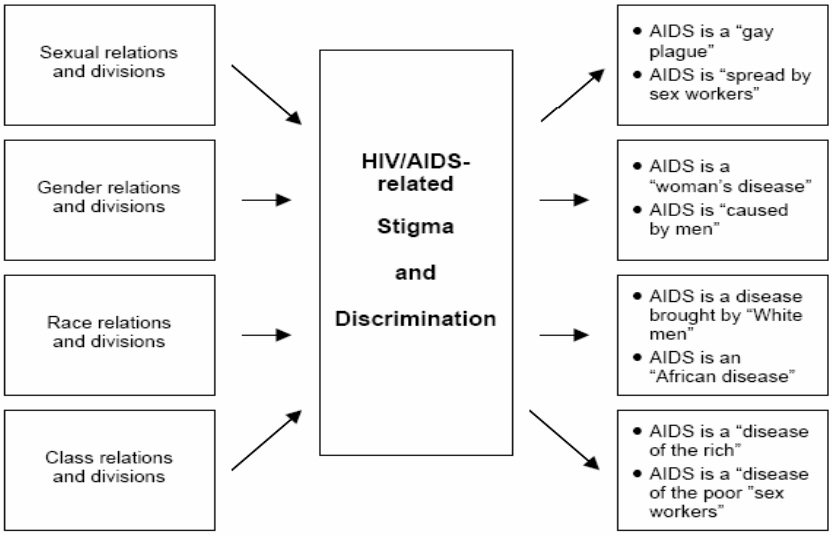
Appendix A1: A Brief History of AIDS



From: UNAIDS, Universal Access Report (2006)

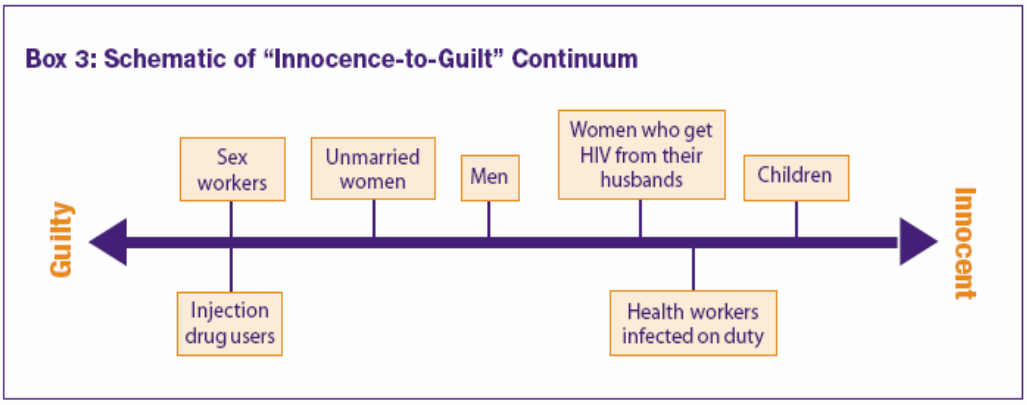
Appendix A2: Link between HIV/AIDS and Stigma and Discrimination

Figure 1 The link between HIV/AIDS and pre-existing sources of S&D



From: Parker et al (2002)

Appendix A3: Innocence to Guilt Continuum



From: ICRW (2005)

APPENDIX B: ANALYSIS FIGURES

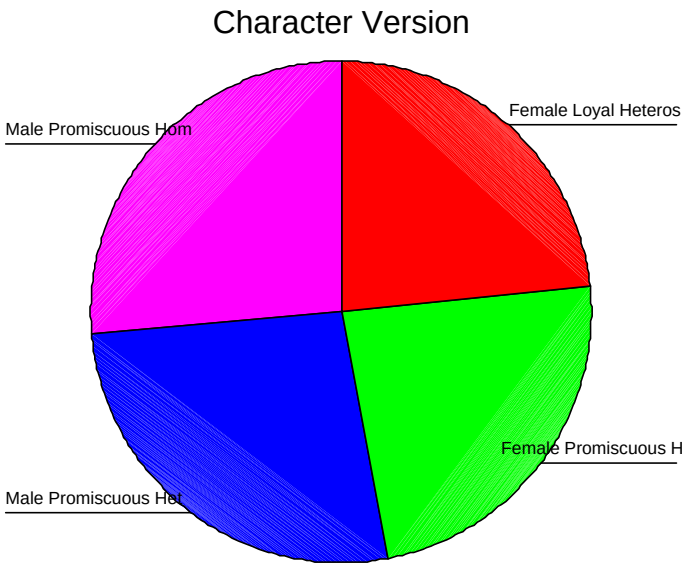
Appendix B1: Descriptive Statistics

		Year of Studies	AGE Age	SEX Sex	Mother's Education	Father's Education	Number of Siblings	Size of City Lived in	Foreign Language Skills	Type of High School	Type of Residence	Experience Abroad
N	Valid	253	232	253	250	253	251	252	253	253	251	249
	Missing	0	21	0	3	0	2	1	0	0	2	4
Mean		2.09	20.34	1.50	2.48	3.09	1.98	3.27	2.46	3.20	1.83	3.69
Median		2.00	20.00	2.00	3.00	3.00	2.00	3.00	2.00	3.00	1.00	4.00
Mode		3	21	2	1	4	1	3	2	3	1	4
Std. Deviation		.936	1.698	.501	1.223	1.098	1.985	.786	.804	.802	1.058	.639

Appendix B2: Character Version Frequency Table and Figure

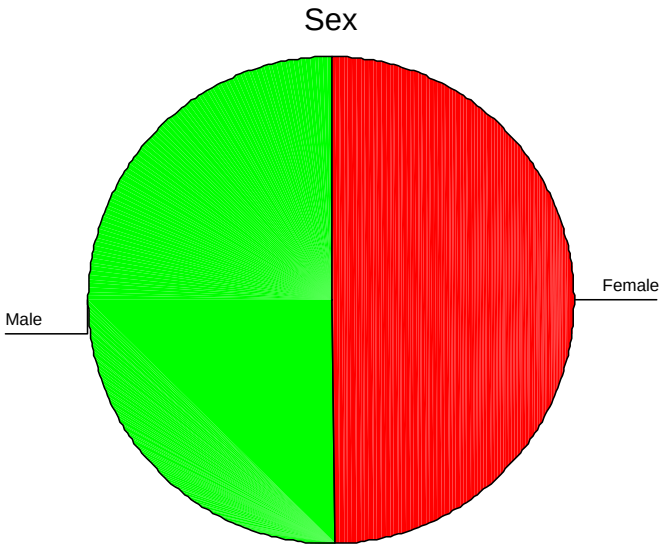
VERSION Character Version

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Female Loyal Heterosexual	59	23.3	23.3	23.3
	2 Female Promiscuous Heterosexual	60	23.7	23.7	47.0
	3 Male Promiscuous Heterosexual	67	26.5	26.5	73.5
	4 Male Promiscuous Homosexual	67	26.5	26.5	100.0
	Total	253	100.0	100.0	



Appendix B3: Sex Frequency Table and Figure

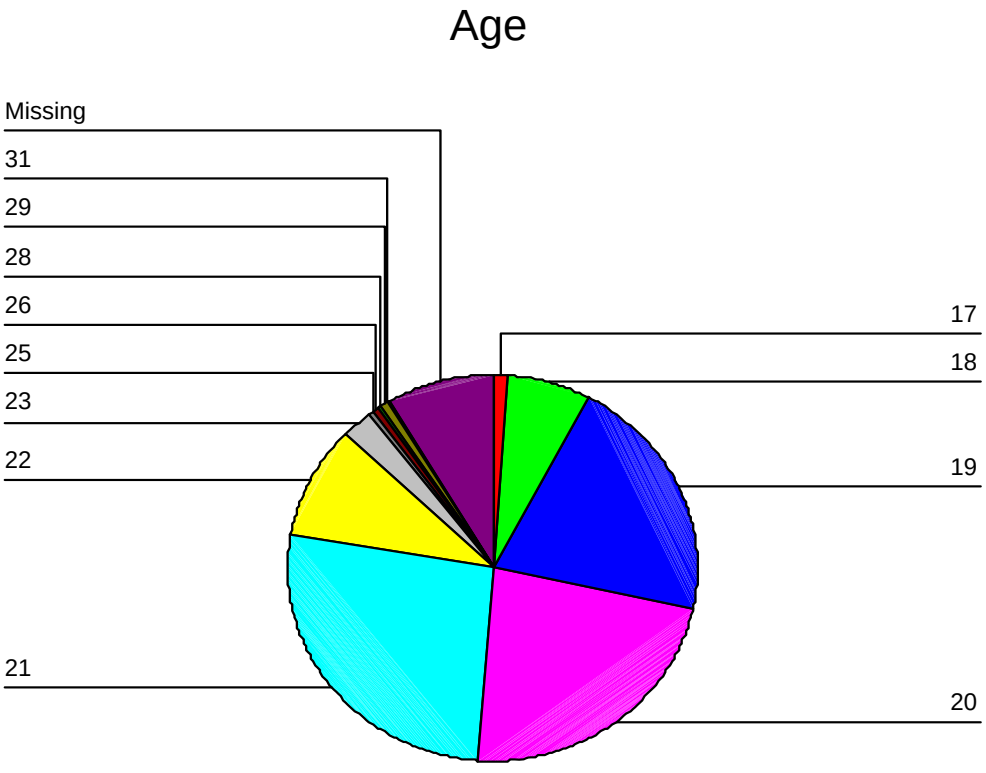
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Female	126	49.8	49.8	49.8
	2 Male	127	50.2	50.2	100.0
	Total	253	100.0	100.0	



Appendix B4: Age Frequency Table and Figure

AGE Age

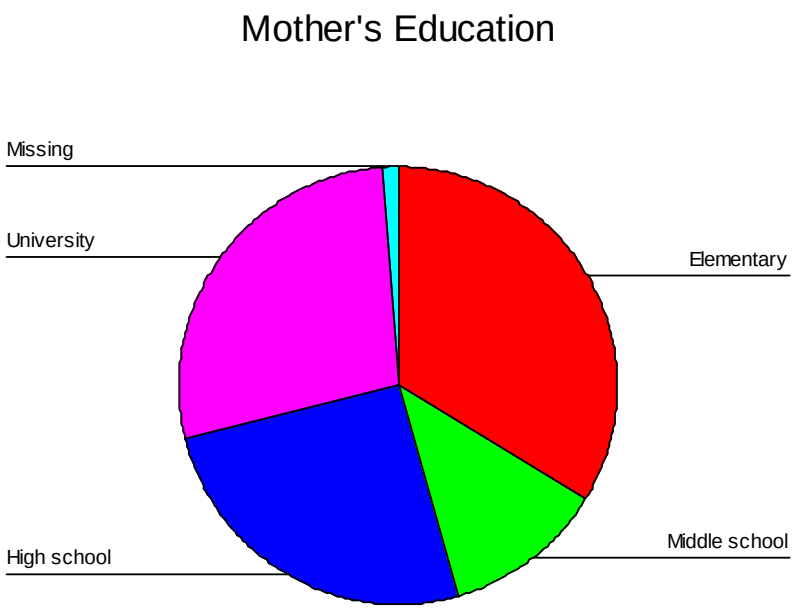
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	17	3	1.2	1.3	1.3
	18	17	6.7	7.3	8.6
	19	52	20.6	22.4	31.0
	20	57	22.5	24.6	55.6
	21	68	26.9	29.3	84.9
	22	24	9.5	10.3	95.3
	23	6	2.4	2.6	97.8
	25	1	.4	.4	98.3
	26	1	.4	.4	98.7
	28	1	.4	.4	99.1
	29	1	.4	.4	99.6
	31	1	.4	.4	100.0
	Total	232	91.7	100.0	
Missing	999	21	8.3		
Total		253	100.0		



Appendix B5: Mother's Education Frequency Table and Figure

MOTHERED Mother's Education

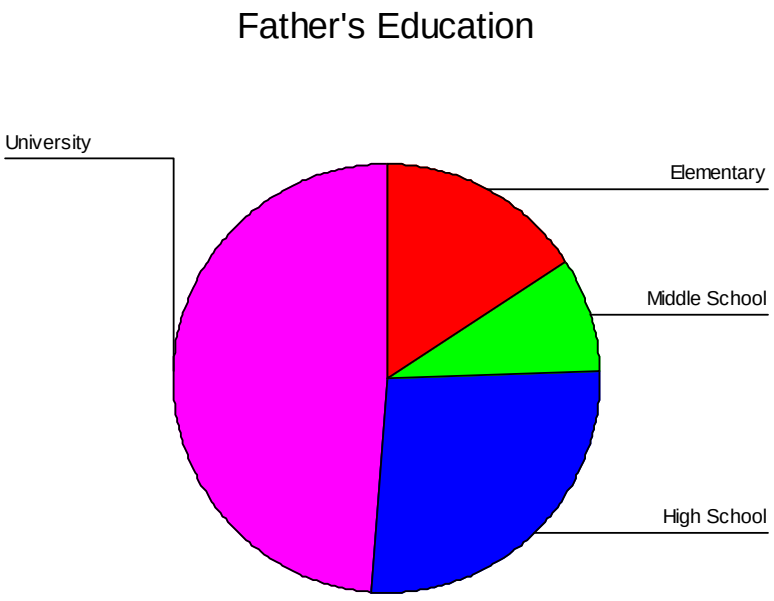
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Elementary	85	33.6	34.0	34.0
	2 Middle school	30	11.9	12.0	46.0
	3 High school	65	25.7	26.0	72.0
	4 University	70	27.7	28.0	100.0
	Total	250	98.8	100.0	
Missing	999	3	1.2		
Total		253	100.0		



Appendix B6: Father's Education Frequency Table and Figure

FATHERED Father's Education

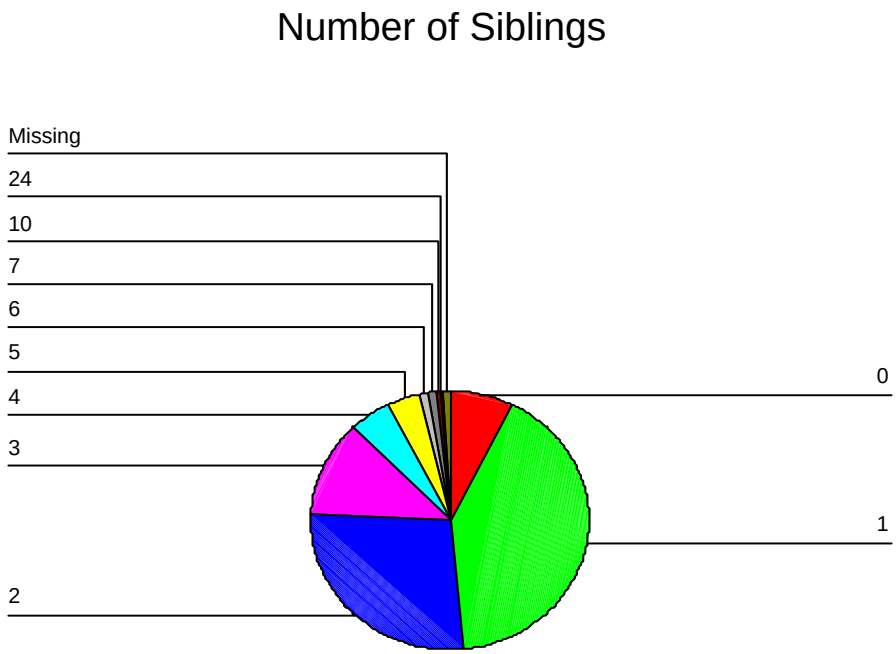
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Elementary	40	15.8	15.8	15.8
	2 Middle School	22	8.7	8.7	24.5
	3 High School	67	26.5	26.5	51.0
	4 University	124	49.0	49.0	100.0
	Total	253	100.0	100.0	



Appendix B7: Number of Siblings Frequency Table and Figure

SIBLING Number of Siblings

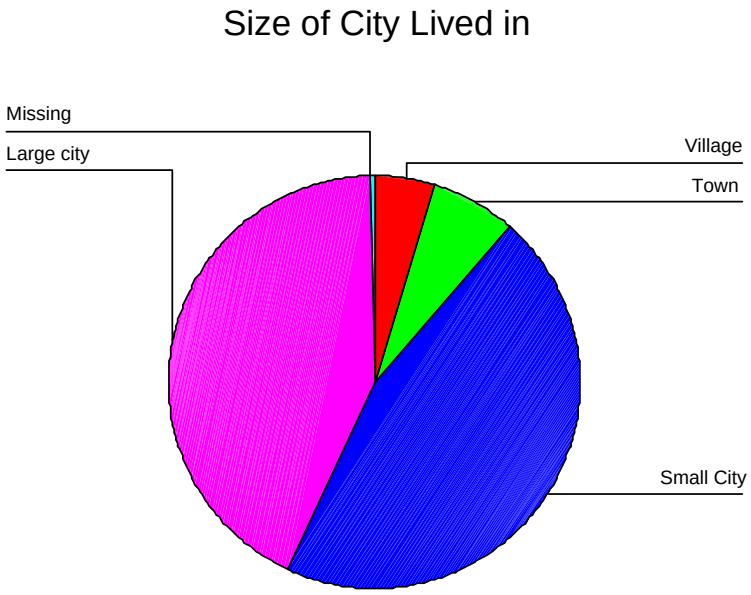
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	18	7.1	7.2	7.2
	1	104	41.1	41.4	48.6
	2	70	27.7	27.9	76.5
	3	30	11.9	12.0	88.4
	4	13	5.1	5.2	93.6
	5	9	3.6	3.6	97.2
	6	3	1.2	1.2	98.4
	7	2	.8	.8	99.2
	10	1	.4	.4	99.6
	24	1	.4	.4	100.0
	Total	251	99.2	100.0	
Missing	999	2	.8		
Total		253	100.0		



Appendix B8: Size of City Frequency Table and Figure

RAISED Size of City Lived in

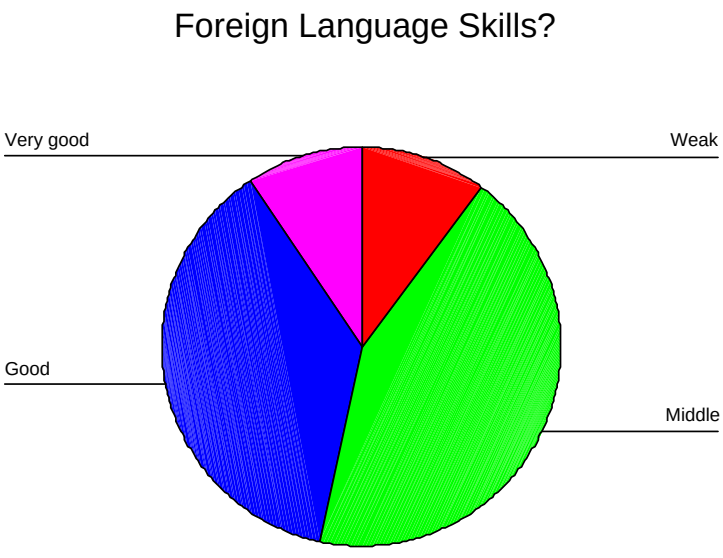
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Village	12	4.7	4.8	4.8
	2 Town	17	6.7	6.7	11.5
	3 Small City	115	45.5	45.6	57.1
	4 Large city	108	42.7	42.9	100.0
	Total	252	99.6	100.0	
Missing	999	1	.4		
Total		253	100.0		



Appendix B9: Foreign Language Skills Frequency Table and Figure

LANG Foreign Language Skills?

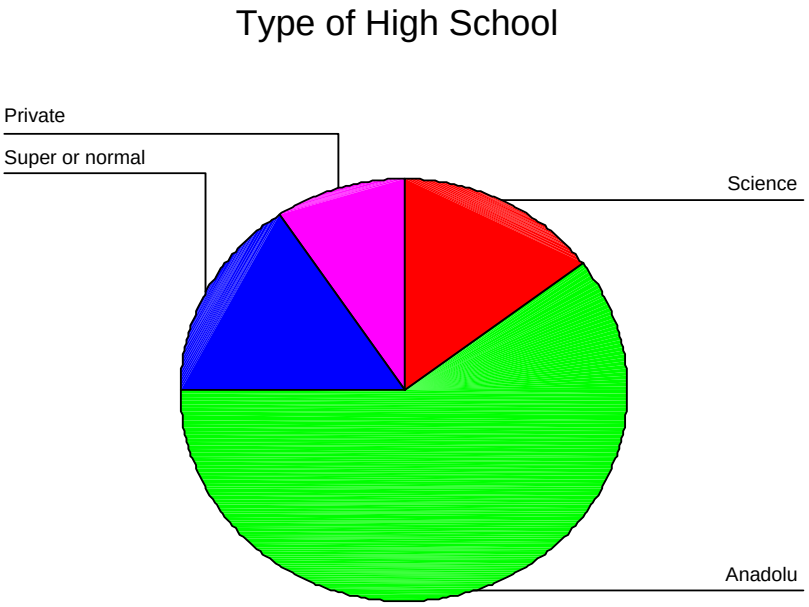
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Weak	26	10.3	10.3	10.3
	2 Middle	109	43.1	43.1	53.4
	3 Good	94	37.2	37.2	90.5
	4 Very good	24	9.5	9.5	100.0
	Total	253	100.0	100.0	



Appendix B10: Type of High School Frequency Table and Figure

HIGHSC Type of High School

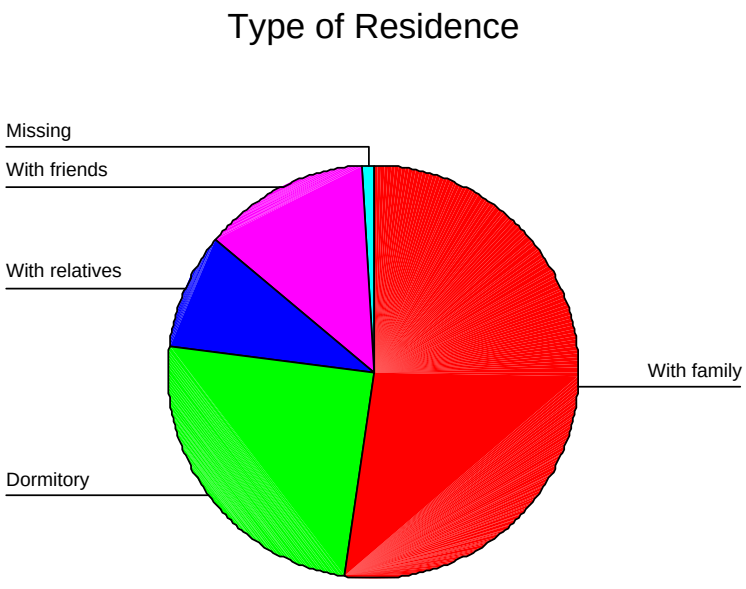
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2 Science	37	14.6	14.6	14.6
	3 Anadolu	153	60.5	60.5	75.1
	4 Super or normal	39	15.4	15.4	90.5
	5 Private	24	9.5	9.5	100.0
	Total	253	100.0	100.0	



Appendix B11: Type of Residence Frequency Table and Figure

RESIDE Type of Residence

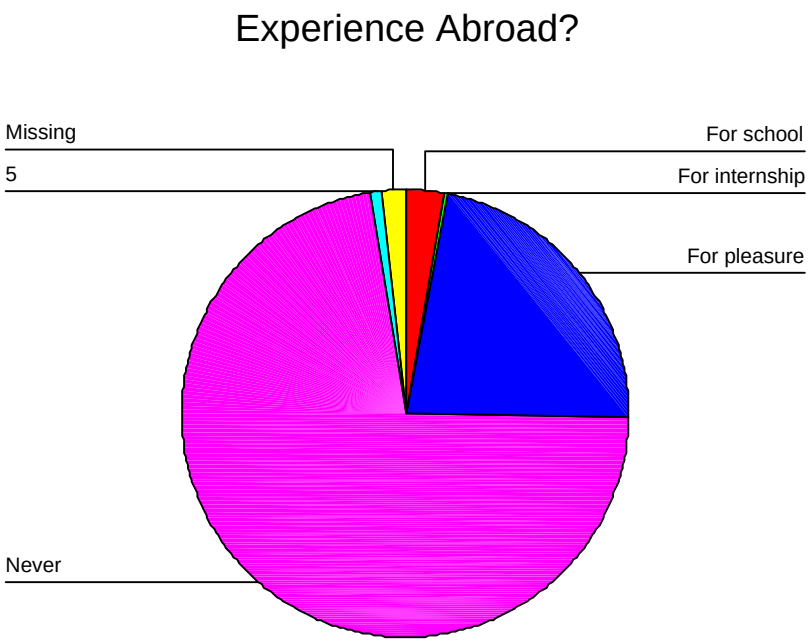
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 With family	132	52.2	52.6	52.6
	2 Dormitory	63	24.9	25.1	77.7
	3 With relatives	23	9.1	9.2	86.9
	4 With friends	33	13.0	13.1	100.0
	Total	251	99.2	100.0	
Missing	999	2	.8		
Total		253	100.0		



Appendix B12: Experience Abroad Frequency Table and Figure

EXPABR Experience Abroad?

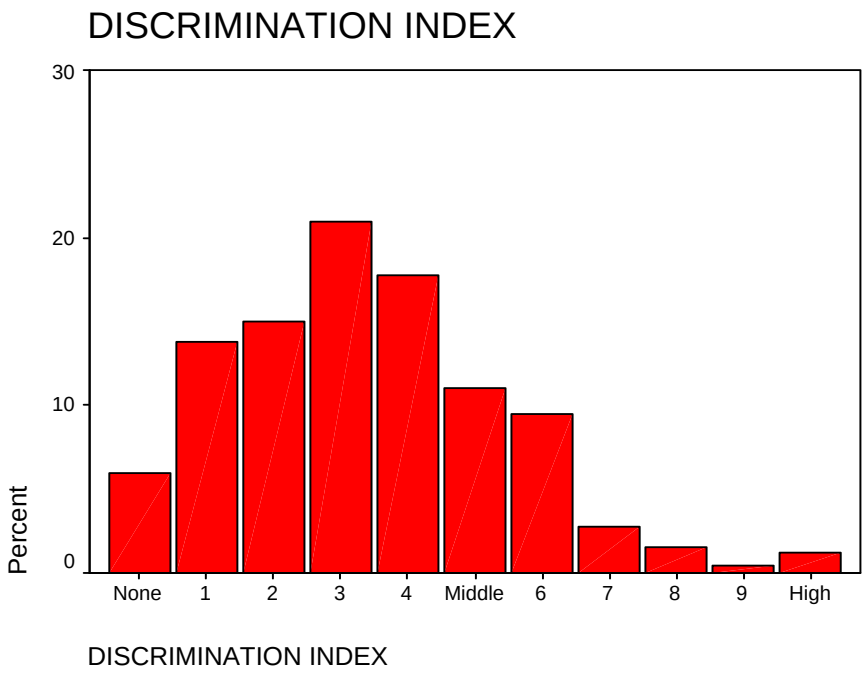
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 For school	7	2.8	2.8	2.8
	2 For internship	1	.4	.4	3.2
	3 For pleasure	56	22.1	22.5	25.7
	4 Never	183	72.3	73.5	99.2
	5	2	.8	.8	100.0
	Total	249	98.4	100.0	
Missing	999	4	1.6		
Total		253	100.0		



Appendix B13: Discrimination Index Frequency Table and Figure

DISCRIM DISCRIMINATION INDEX

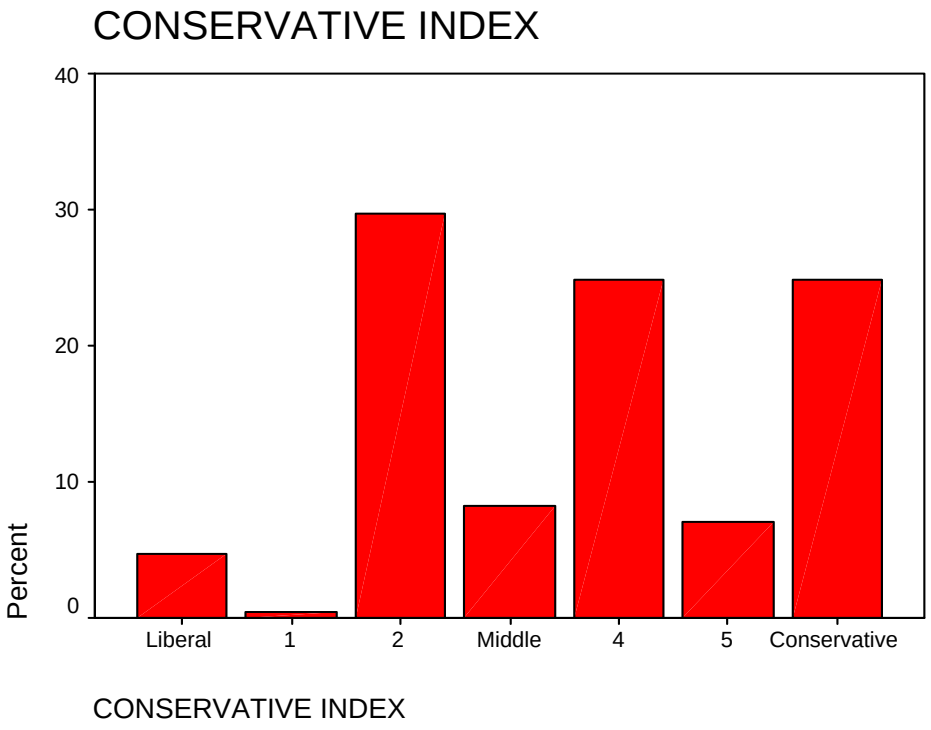
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 None	15	5.9	5.9	5.9
	1	35	13.8	13.8	19.8
	2	38	15.0	15.0	34.8
	3	53	20.9	20.9	55.7
	4	45	17.8	17.8	73.5
	5 Middle	28	11.1	11.1	84.6
	6	24	9.5	9.5	94.1
	7	7	2.8	2.8	96.8
	8	4	1.6	1.6	98.4
	9	1	.4	.4	98.8
	10 High	3	1.2	1.2	100.0
	Total	253	100.0	100.0	



Appendix B14: Conservatism Index Frequency Table and Figure

CONSERV CONSERVATIVE INDEX

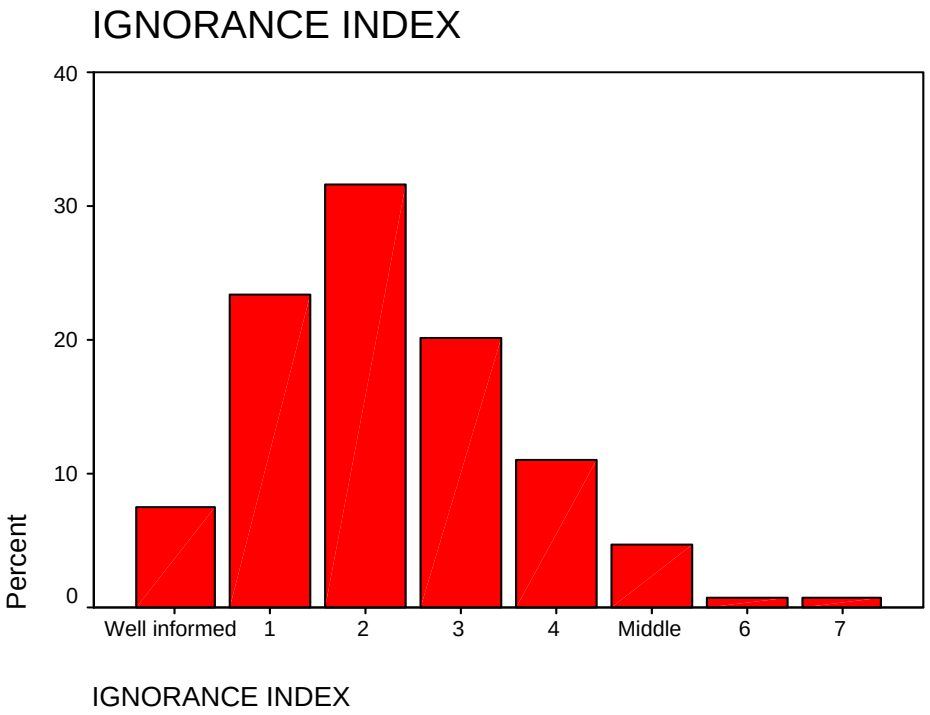
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 Liberal	12	4.7	4.7	4.7
	1	1	.4	.4	5.1
	2	75	29.6	29.6	34.8
	3 Middle	21	8.3	8.3	43.1
	4	63	24.9	24.9	68.0
	5	18	7.1	7.1	75.1
	6 Conservative	63	24.9	24.9	100.0
	Total	253	100.0	100.0	



Appendix B15: Ignorance Index Frequency Table and Figure

IGNORTOT IGNORANCE INDEX

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 Well informed	19	7.5	7.5	7.5
	1	59	23.3	23.3	30.8
	2	80	31.6	31.6	62.5
	3	51	20.2	20.2	82.6
	4	28	11.1	11.1	93.7
	5 Middle	12	4.7	4.7	98.4
	6	2	.8	.8	99.2
	7	2	.8	.8	100.0
	Total	253	100.0	100.0	



Appendix B16: Questions Regarding Attitudes towards the Characters

		Character Version							
		1 Female Loyal Heterosexual		2 Female Promiscuous Heterosexual		3 Male Promiscuous Heterosexual		4 Male Promiscuous Homosexual	
		Sex		Sex		Sex		Sex	
QUESTION	RESPONSE	1 Female	2 Male	1 Female	2 Male	1 Female	2 Male	1 Female	2 Male
Avoid Seeing Deniz?	0 No	91.7%	91.3%	83.9%	93.1%	100.0%	76.9%	87.1%	80.6%
	1 Yes	8.3%	8.7%	16.1%	6.9%		23.1%	12.9%	19.4%
Worry about contracting HIV at office	0 No	44.4%	39.1%	51.6%	50.0%	63.0%	41.0%	48.4%	47.2%
	1 Yes	55.6%	60.9%	48.4%	50.0%	37.0%	59.0%	51.6%	52.8%
Would do research for support	0 Yes	94.4%	87.0%	100.0%	89.7%	92.9%	84.2%	93.5%	91.7%
	1 No	5.6%	13.0%		10.3%	7.1%	15.8%	6.5%	8.3%
Contracted through inappropriate beh.	0 No	86.1%	65.2%	12.9%	35.7%	37.0%	23.1%	22.6%	13.9%
	1 Yes	13.9%	34.8%	87.1%	64.3%	63.0%	76.9%	77.4%	86.1%
Rejection by family if status revealed	0 No	94.4%	82.6%	90.3%	75.0%	92.9%	76.3%	80.6%	74.3%
	1 Yes	5.6%	17.4%	9.7%	25.0%	7.1%	23.7%	19.4%	25.7%
Uncomfortable for working in same office	0 No	74.3%	60.9%	67.7%	79.3%	63.0%	59.0%	61.3%	58.3%
	1 Yes	25.7%	39.1%	32.3%	20.7%	37.0%	41.0%	38.7%	41.7%
Warn the others in the office	0 No	91.2%	65.2%	64.5%	75.9%	64.3%	56.4%	80.6%	75.0%
	1 Yes	8.8%	34.8%	35.5%	24.1%	35.7%	43.6%	19.4%	25.0%
Avoid kissing Deniz on the cheek	0 No	69.4%	52.2%	64.5%	67.9%	66.7%	46.2%	61.3%	47.2%
	1 Yes	30.6%	47.8%	35.5%	32.1%	33.3%	53.8%	38.7%	52.8%
Deniz had inappropriate sexual behaviour	0 No	83.3%	69.6%	29.0%	34.5%	42.9%	20.5%	22.6%	13.9%
	1 Yes	16.7%	30.4%	71.0%	65.5%	57.1%	79.5%	77.4%	86.1%
Deniz deserved this virus	0 No	100.0%	95.7%	90.3%	62.1%	92.9%	68.4%	80.6%	55.6%
	1 Yes		4.3%	9.7%	37.9%	7.1%	31.6%	19.4%	44.4%

Appendix B17: Questions Regarding Knowledge of HIV

QUESTION	RESPONSE	Sex	
		1 Female	2 Male
HIV test time	1 Immediately	44.4%	40.5%
	2 One month later	8.9%	7.1%
	3 3 to 6 months later	20.2%	27.0%
	4 Don't know	26.6%	25.4%
Information on treatment	1 Fear of contracting HIV	1.6%	7.3%
	2 Delay appointment and learn	54.8%	49.2%
	4 Treatment with universal precautions	38.1%	37.1%
	5 Other	5.6%	6.5%

QUESTION	RESPONSE	Sex	
		1 Female	2 Male
Contracting by sharing a phone	0 Correct	98.4%	96.9%
	1 Wrong	1.6%	3.1%
Contracting by shaking hands	0 Correct	100.0%	98.4%
	1 Wrong	.0%	1.6%
Contracting by coughing and sneeze	0 Correct	78.7%	71.0%
	1 Wrong	21.3%	29.0%
Contracting by sharing toilet	0 Correct	62.4%	72.0%
	1 Wrong	37.6%	28.0%
Contracting by sharing utensils	0 Correct	73.0%	66.4%
	1 Wrong	27.0%	33.6%
HIV positives may not know their status	0 Correct	82.1%	87.2%
	1 Wrong	17.9%	12.8%
Contracting during pregnancy or at birth	0 Correct	93.4%	90.4%
	1 Wrong	6.6%	9.6%
Contracting by mosquitoes	0 Correct	42.3%	34.4%
	1 Wrong	57.7%	65.6%
Contracting by breast milk	0 Correct	51.8%	43.9%
	1 Wrong	48.2%	56.1%
Contracting by sharing a phone	0 Correct	97.6%	96.8%
	1 Wrong	2.4%	3.2%
Contracting by unprotected sex	0 Correct	98.4%	98.4%
	1 Wrong	1.6%	1.6%

Appendix B18: Questions Regarding Conservative Views

		Sex	
		1 Female	2 Male
I have an HIV positive friend	0 Yes	1.6%	.8%
	1 No	98.4%	99.2%
I have adequate info on HIV	0 No	72.8%	55.1%
	1 Yes	27.2%	44.9%
Continue to see gay male friend	0 Yes	66.7%	47.1%
	2 No	33.3%	52.9%
View on multiple partners for man	0 Yes	6.5%	14.5%
	1 Some	46.0%	49.2%
	2 No	47.6%	36.3%
View on multiple partners for woman	0 Liberal	4.8%	5.5%
	1 Middle	40.3%	23.6%
	2 Conservative	54.8%	70.9%

Appendix B19: Subject Variable T-Test
Female vs Male Respondents Discrimination Levels

Group Statistics

	SEX Sex	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 Female	126	2.84	1.869	.167
	2 Male	127	3.91	2.064	.183

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION IND	Equal variances assumed	.691	.407	-4.297	251	.000	-1.06	.248	-1.552	-.576
	Equal variances not assumed			-4.299	248.943	.000	-1.06	.248	-1.552	-.577

Appendix B20: Subject Variable Nonparametric Correlations

Tests if any other subject variable has a significant effect on the value of Discrimination Index

Correlations

			DISCRIM DISCRIMINATION INDEX	CLASS Year of Studies	AGE Age	MOTHERED Mother's Education	FATHERED Father's Education	SIBLING Number of Siblings	LANG Foreign Language Skills?	HIGHSC Type of High School	RESIDE Type of Residence
Spearman's rho	DISCRIM DISCRIMINATION INDEX	Correlation Coefficient	1.000	.054	.062	.028	.000	.085	-.077	.022	.080
		Sig. (2-tailed)	.	.390	.346	.656	.995	.181	.222	.729	.206
		N	253	253	232	250	253	251	253	253	251
	CLASS Year of Studies	Correlation Coefficient	.054	1.000	.771**	-.051	-.042	.073	.072	-.026	-.003
		Sig. (2-tailed)	.390	.	.000	.420	.509	.252	.253	.681	.959
		N	253	253	232	250	253	251	253	253	251
	AGE Age	Correlation Coefficient	.062	.771**	1.000	-.043	-.020	.116	.086	-.127	.026
		Sig. (2-tailed)	.346	.000	.	.522	.765	.080	.191	.053	.693
		N	232	232	232	229	232	230	232	232	230
	MOTHERED Mother's Education	Correlation Coefficient	.028	-.051	-.043	1.000	.610**	-.374**	.356**	-.115	-.035
		Sig. (2-tailed)	.656	.420	.522	.	.000	.000	.000	.070	.581
		N	250	250	229	250	250	248	250	250	248
	FATHERED Father's Education	Correlation Coefficient	.000	-.042	-.020	.610**	1.000	-.250**	.198**	-.033	.022
		Sig. (2-tailed)	.995	.509	.765	.000	.	.000	.002	.596	.733
		N	253	253	232	250	253	251	253	253	251
	SIBLING Number of Siblings	Correlation Coefficient	.085	.073	.116	-.374**	-.250**	1.000	-.275**	.076	.191**
		Sig. (2-tailed)	.181	.252	.080	.000	.000	.	.000	.229	.002
		N	251	251	230	248	251	251	251	251	249
	LANG Foreign Language Skills?	Correlation Coefficient	-.077	.072	.086	.356**	.198**	-.275**	1.000	.108	-.221**
		Sig. (2-tailed)	.222	.253	.191	.000	.002	.000	.	.085	.000
		N	253	253	232	250	253	251	253	253	251
	HIGHSC Type of High School	Correlation Coefficient	.022	-.026	-.127	-.115	-.033	.076	.108	1.000	-.156*
		Sig. (2-tailed)	.729	.681	.053	.070	.596	.229	.085	.	.013
		N	253	253	232	250	253	251	253	253	251
	RESIDE Type of Residence	Correlation Coefficient	.080	-.003	.026	-.035	.022	.191**	-.221**	-.156*	1.000
		Sig. (2-tailed)	.206	.959	.693	.581	.733	.002	.000	.013	.
		N	251	251	230	248	251	249	251	251	251

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Appendix B21: Analysis 1a: One-Way ANOVA with All Respondents

Discrimination against the four characters

Oneway

ANOVA

DISCRIM DISCRIMINATION INDEX

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	125.795	3	41.932	11.355	.000
Within Groups	919.533	249	3.693		
Total	1045.328	252			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: DISCRIM DISCRIMINATION INDEX

Bonferroni

(I) VERSION Character Version	(J) VERSION Character Version	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1 Female Loyal Heterosexual	2 Female Promiscuous Heterosexual	-1.21*	.352	.004	-2.15	-.28
	3 Male Promiscuous Heterosexual	-1.59*	.343	.000	-2.50	-.68
	4 Male Promiscuous Homosexual	-1.88*	.343	.000	-2.79	-.96
2 Female Promiscuous Heterosexual	1 Female Loyal Heterosexual	1.21*	.352	.004	.28	2.15
	3 Male Promiscuous Heterosexual	-.38	.342	1.000	-1.29	.53
	4 Male Promiscuous Homosexual	-.66	.342	.324	-1.57	.25
3 Male Promiscuous Heterosexual	1 Female Loyal Heterosexual	1.59*	.343	.000	.68	2.50
	2 Female Promiscuous Heterosexual	.38	.342	1.000	-.53	1.29
	4 Male Promiscuous Homosexual	-.28	.332	1.000	-1.17	.60
4 Male Promiscuous Homosexual	1 Female Loyal Heterosexual	1.88*	.343	.000	.96	2.79
	2 Female Promiscuous Heterosexual	.66	.342	.324	-.25	1.57
	3 Male Promiscuous Heterosexual	.28	.332	1.000	-.60	1.17

*. The mean difference is significant at the .05 level.

Appendix B22: Analysis 1b: One-Way ANOVA with Female Respondents Only

Discrimination against the four characters

Oneway

ANOVA

DISCRIM DISCRIMINATION INDEX

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	77.440	3	25.813	8.763	.000
Within Groups	359.385	122	2.946		
Total	436.825	125			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: DISCRIM DISCRIMINATION INDEX

Bonferroni

(I) VERSION Character Version	(J) VERSION Character Version	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1 Female Loyal Heterosexual	2 Female Promiscuous Heterosexual	-1.76*	.421	.000	-2.89	-.63
	3 Male Promiscuous Heterosexual	-1.09	.432	.077	-2.25	.07
	4 Male Promiscuous Homosexual	-1.92*	.421	.000	-3.05	-.79
2 Female Promiscuous Heterosexual	1 Female Loyal Heterosexual	1.76*	.421	.000	.63	2.89
	3 Male Promiscuous Heterosexual	.67	.447	.836	-.53	1.87
	4 Male Promiscuous Homosexual	-.16	.436	1.000	-1.33	1.01
3 Male Promiscuous Heterosexual	1 Female Loyal Heterosexual	1.09	.432	.077	-.07	2.25
	2 Female Promiscuous Heterosexual	-.67	.447	.836	-1.87	.53
	4 Male Promiscuous Homosexual	-.83	.447	.402	-2.03	.37
4 Male Promiscuous Homosexual	1 Female Loyal Heterosexual	1.92*	.421	.000	.79	3.05
	2 Female Promiscuous Heterosexual	.16	.436	1.000	-1.01	1.33
	3 Male Promiscuous Heterosexual	.83	.447	.402	-.37	2.03

*. The mean difference is significant at the .05 level.

Appendix B23: Analysis 1c: One-Way ANOVA with Male Respondents Only

Discrimination against the four characters

Oneway

ANOVA

DISCRIM DISCRIMINATION INDEX

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	54.391	3	18.130	4.622	.004
Within Groups	482.475	123	3.923		
Total	536.866	126			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: DISCRIM DISCRIMINATION INDEX

Bonferroni

(I) VERSION Character Version	(J) VERSION Character Version	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1 Female Loyal Heterosexual	2 Female Promiscuous Heterosexual	-.40	.553	1.000	-1.88	1.09
	3 Male Promiscuous Heterosexual	-1.55*	.521	.021	-2.94	-.15
	4 Male Promiscuous Homosexual	-1.50*	.529	.031	-2.92	-.09
2 Female Promiscuous Heterosexual	1 Female Loyal Heterosexual	.40	.553	1.000	-1.09	1.88
	3 Male Promiscuous Heterosexual	-1.15	.486	.116	-2.45	.15
	4 Male Promiscuous Homosexual	-1.11	.494	.162	-2.43	.22
3 Male Promiscuous Heterosexual	1 Female Loyal Heterosexual	1.55*	.521	.021	.15	2.94
	2 Female Promiscuous Heterosexual	1.15	.486	.116	-.15	2.45
	4 Male Promiscuous Homosexual	.04	.458	1.000	-1.18	1.27
4 Male Promiscuous Homosexual	1 Female Loyal Heterosexual	1.50*	.529	.031	.09	2.92
	2 Female Promiscuous Heterosexual	1.11	.494	.162	-.22	2.43
	3 Male Promiscuous Heterosexual	-.04	.458	1.000	-1.27	1.18

*. The mean difference is significant at the .05 level.

Appendix B24: Analysis 2a: Discrimination Moderated by Normalized Sexuality for All Respondents

T-Test

Group Statistics

	NORMSEX 1 is normal, 2 is deviant	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 normal sex.	126	3.02	2.154	.192
	2 deviant	127	3.73	1.854	.164

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	1.760	.186	-2.836	251	.005	-.72	.253	-1.214	-.219
	Equal variances not assumed			-2.835	244.966	.005	-.72	.253	-1.214	-.219

Appendix B25: Analysis 2b: Discrimination Moderated by Normalized Sexuality for Female Respondents Only

T-Test

Group Statistics

	NORMSEX 1 is normal, 2 is deviant	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 normal sex.	64	2.17	1.742	.218
	2 deviant	62	3.53	1.753	.223

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	.030	.862	-4.369	124	.000	-1.36	.311	-1.977	-.744
	Equal variances not assumed			-4.369	123.817	.000	-1.36	.311	-1.977	-.744

Appendix B26: Analysis 2c: Discrimination Moderated by Normalized Sexuality for Male Respondents Only

T-Test

Group Statistics

	NORMSEX 1 is normal, 2 is deviant	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 normal sex.	62	3.89	2.204	.280
	2 deviant	65	3.92	1.939	.240

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	.461	.498	-.098	125	.922	-.04	.368	-.764	.692
	Equal variances not assumed			-.098	121.308	.922	-.04	.369	-.766	.695

Appendix B27: Analysis 3a: Discrimination Moderated by Gender Bias for All Respondents

T-Test

Group Statistics

	MVSF 1 is female, 2 is male character	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 Females from Group 1 and 2	119	2.78	1.984	.182
	3 Males from Group 3 and 4	134	3.90	1.942	.168

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	.219	.640	-4.538	251	.000	-1.12	.247	-1.608	-.635
	Equal variances not assumed			-4.533	246.156	.000	-1.12	.247	-1.609	-.634

Appendix B28: Analysis 3b: Discrimination Moderated by Gender Bias for Female Respondents Only

T-Test

Group Statistics

	MVSF 1 is female, 2 is male character	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 Females from Group 1 and 2	67	2.51	1.870	.228
	3 Males from Group 3 and 4	59	3.22	1.811	.236

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	.060	.806	-2.167	124	.032	-.71	.329	-1.364	-.062
	Equal variances not assumed			-2.172	122.865	.032	-.71	.328	-1.363	-.063

Appendix B29: Analysis 3c: Discrimination Moderated by Gender Bias for Male Respondents Only

T-Test

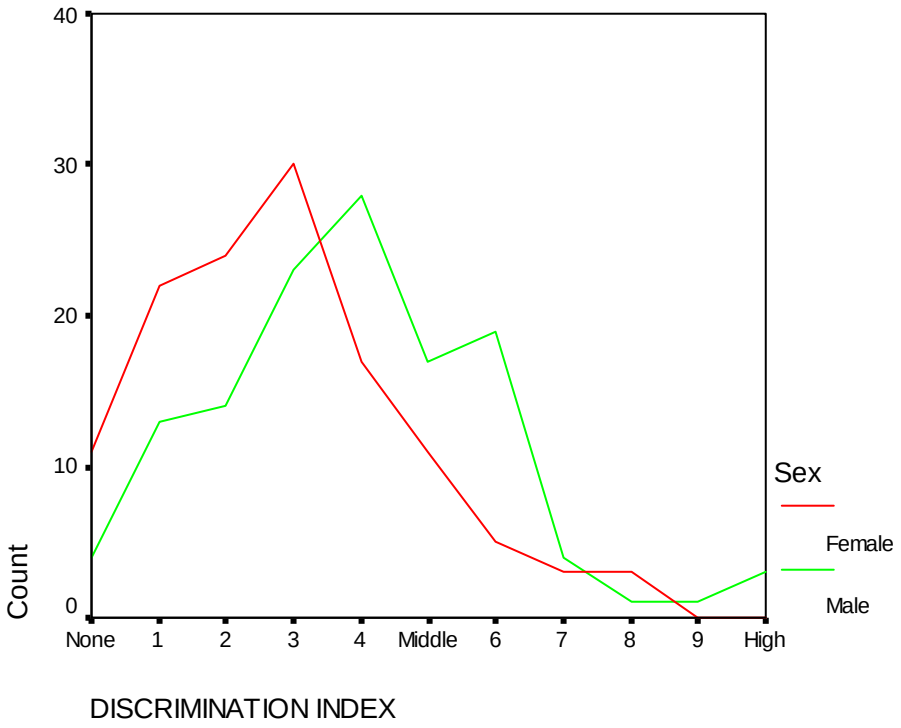
Group Statistics

	MVSF 1 is female, 2 is male character	N	Mean	Std. Deviation	Std. Error Mean
DISCRIM DISCRIMINATION INDEX	1 Females from Group 1 and 2	52	3.13	2.087	.289
	3 Males from Group 3 and 4	75	4.44	1.883	.217

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
DISCRIM DISCRIMINATION INDEX	Equal variances assumed	.818	.368	-3.674	125	.000	-1.31	.355	-2.009	-.602
	Equal variances not assumed			-3.606	102.373	.000	-1.31	.362	-2.023	-.587

Appendix B30: Discrimination Levels for Female and Male Respondents



Appendix B31: Index Correlations

Discrimination Index vs Conservatism Index vs Ignorance Index

Correlations

		DISCRIM DISCRIMINATION INDEX	CONSERV CONSERVATIVE INDEX	IGNORTOT IGNORANCE INDEX
DISCRIM DISCRIMINATION INDEX	Pearson Correlation	1	.231**	.186**
	Sig. (2-tailed)	.	.000	.003
	N	253	253	253
CONSERV CONSERVATIVE INDEX	Pearson Correlation	.231**	1	.026
	Sig. (2-tailed)	.000	.	.679
	N	253	253	253
IGNORTOT IGNORANCE INDEX	Pearson Correlation	.186**	.026	1
	Sig. (2-tailed)	.003	.679	.
	N	253	253	253

**. Correlation is significant at the 0.01 level (2-tailed).

APPENDIX C: QUALITATIVE QUESTIONS

Kalitatif Görüşme Soruları

1. Tanı konmadan önce HIV ve AIDS hakkında ne biliyordun?

2. HIV durumunu nasıl öğrendin? (ameliyat, hastalık mı ?)

3. Durumunu öğrendiğinde AIDS hakkında ilk aklına gelen tanımlama ne idi?

4. Durumunu öğrendiğinde ne düşündün? (hem kendi adına, hem ailen ve arkadaş çevren adına neler düşündün?)

5. Durumunu ailenle paylaşabildin mi?
    a. Evetse, ailenle paylaştığında, sana hangi soruları sordular? Ailenle paylaşırken en zor yanı neydi? Ailenle paylaşırken, destek alamama ihtimalini düşündünmü?
    b. Hayırsa, neden anlatamadın?

6. Durumunu arkadaş çevrene anlatabildin mi?
    a. Evetse, nasıl anlattın? Anlatırken en zor yanı neydi? Arkadaşlarınla paylaşırken, destek alamama ihtimalini düşündünmü?
    b. Hayırsa, neden anlatamadın?

7. Şu an durumunu arkadaş çevrene anlatabiliyor musun? Neden?

8. Şu an kimler sana en çok destek oluyor? Arkadaşlar, aile? Nasıl destek oluyorlar?

9. Iş çevren biliyor mu?
    a. Bilmiyorsa neden?
    b. Biliyorsa, nasıl açıkladın?

10. Tanı konulduğunda ilk ne düşündün? Virüsü veya hastalık, sende nasıl bir çağrışım yaptı?

11. Durumunu açıklamak zorunda kaldığında cinsellik faktörü karşına çıkıyor mu? Açıklarmısın?

12. Cinsellik ve HIV bağlantısı hakkında ne düşünüyorsun?

13. Sence heteroseksüel ilişki HIV'i açıklamakta bir kolaylık mı? Açıklarmısın?

14. Tanı konduğunda doktor sana hangi soruları sordu? Doktorun sormaması gerekli soruları sorduğunu düşündünmü? Doktorun, davranmaması gerektiği gibi davrandığını hissettinmi? Doktordan herhangi bir baskı hissettin mi?

15. Doktora ne söylemek istedin? Ne söyledin? Yalan söyleme ihtiyacı hissettin mi? Evetse, hangi konuda yalan söyleme ihtiyacı hissettin?

16. Şu an doktora veya diş hekimine gittiğinde durumunu açıklamak zorunda kalıyormusun? Neler soruyorlar? Nasıl davranıyorlar? Uygunsuz davranan oluyor mu? Neden böyle davrandıklarını düşünüyorsun?

17. Doktora gitmek durumunda kaldığında ve tedavi ihtiyacın olduğunda veya olacağını düşündüğünde hangi zorluklar karşına çıkıyor/çıkabilir?

18. Sence HIV'e karşı bir önyargı var mı? Bu önyargı sence doğru mu? Bu önyargının nereden kaynaklandığını düşünüyorsun?

APPENDIX D: QUANTITATIVE QUESTIONS

ODTÜ Sosyal Bilimler Enstitüsü
Araştırma Anket Formu

Bu anket, Ortadoğu Teknik Üniversitesi Sosyoloji Ana Bilim Dalı'ndan Prof. Dr. Yakın Ertürk'ün danışmanlığında, AIDS ile ilgili bilgi ve düşüncelerin araştırılabilmesi amacıyla, Dt. Serap Aşar Brown tarafından düzenlenmiştir.

Bu çalışma tamamiyle anonim değerlendirilecek olduğundan, lütfen isminizi belirtmeyiniz. Vereceğiniz her yanıt, araştırmanın doğru sonuçlara ulaşabilmesini sağlayacaktır, lütfen soruları eksiksiz doldurunuz. **Araştırmanın güvenilebilir olması için, tüm soruları gerçeğe en yakın bir şekilde yanıtlamanız oldukça önemlidir.** Değerli katkınızdan dolayı çok teşekkür ederiz.

I- Genel bilgiler:

1. Yaşınız:
2. Cinsiyetiniz: **A)** Kadın **B)** Erkek
3. Annenizin eğitimi: **A)** İlkokul **B)** Ortaokul **C)** Lise **D)** Üniversite
4. Babanızın eğitimi: **A)** İlkokul **B)** Ortaokul **C)** Lise **D)** Üniversite
5. Annenizin mesleği:
6. Babanızın mesleği:
7. Kardeş sayısı:
8. 0-12 yaş arası nerede büyüdünüz? **A)** Köy **B)** Kasaba **C)** Küçük Kent **D)** Metropol
9. Yabancı dil bilginiz nedir? **A)** Zayıf **B)** Orta **C)** İyi **D)** Çok iyi

10. Üniversiteye girmeden önce hangi tip lisede eğitim gördünüz? **A)** Meslek **B)** Fen **C)** Anadolu **D)** Süper lise/normal **E)** Özel
11. Okula devam ettiğiniz dönemde nerede kalıyorsunuz? **A)** Ailemle **B)** Yurtta **C)** Akraba/kardeşimle **D)**Arkadaşlarımla
12. Yurt dışı deneyiminiz var mı? **A)** Ders amaçlı **B)** Staj **C)** Gezi amaçlı **D)** Hayır, hiç olmadı

II. Lütfen aşağıdaki metni okuyup, takip eden sorular için size en uygun cevabı seçiniz.

Deniz, çocukluğunuzdan tanıdığınız yakın bir kız arkadaşınız. Deniz ile hala arkadaşlığınız devam etmekte ve bir ilaç şirketinde part-time olarak beraber çalışmaktasınız. Deniz kısa bir zaman önce evlendi ve bugüne kadar hayatında eşinden başka hiç kimseyle bir ilişkisi olmadı.

Bugün Deniz ofiste yanınıza geldi ve sizinle çok önemli bir şey konuşmak istediğini söyledi. İş çıkışında beraber bir yere çay içmeye gittiniz. Deniz size dün hastaneye gittiğini, geçen hafta yaptırmış olduğu kan testi sonuçlarını aldığını ve HIV pozitif olduğunu öğrendiğini söyledi. Doktorunun ona virüsü eşinden almış olabileceğini belirttiğini de ekledi. Deniz size, özellikle ofisteki arkadaşlarının onun hakkında ne düşüneceğinden oldukça huzursuz olduğunu söyledi ve bu konuyu sizden sır olarak saklamanızı rica etti.

Deniz ile aynı büroda çalışıyorsunuz, aynı ortamdaki eşyaları, telefonu ve banyoyu ortak kullanıyorsunuz. Deniz'in HIV pozitif olduğunu öğrendikten sonra ne hissederdeniz?

1. Deniz ile tekrar görüşmekten kaçınır mıydınız?
   A. Evet B. Hayır

2. Deniz ile aynı ofis ortamında çalışırken bu virüsü almış olacağınızdan endişe eder miydiniz?
   A. Evet B. Hayır

3. Deniz'e destek olabilmek için HIV ve AIDS hakkında bir araştırma yapar mıydınız?
   A. Evet B. Hayır

4. Deniz'in bu virüsü almış olmasının, onun uygunsuz bir davranışından dolayı olduğunu düşünür müydünüz?
   A. Evet B. Hayır

5. Deniz'in bu durumunu ailesiyle paylaşmaması gerektiğini çünkü ailesinin onu reddedeceğini düşünür müydünüz?
   A. Evet B. Hayır

6. Deniz'in HIV pozitif olduğunu öğrendikten sonra onunla aynı ortamda çalışmaktan rahatsız olur muydunuz?
   A. Evet B. Hayır

7. Ofis ortamındakilere Deniz'in HIV pozitif olduğunu söyleyip, onları uyarır mıydınız?
   A. Evet B. Hayır

8. Bundan böyle Deniz'i görünce onu yanağından öpmekten kaçınır mıydınız?
   A. Evet B. Hayır

9. Deniz'in cinsel yaşantısının uygunsuz olduğunu düşünür müydünüz?
   A. Evet B. Hayır

10. Deniz'in bu virüsü haketmiş olduğunu düşünür müydünüz?
    A. Evet B. Hayır

III. Lütfen aşağıdaki soruları sizce doğru olan seçenek ile yanıtlayınız.

11. Hiç HIV pozitif bir arkadaşınız var mı?
    A. Evet B. Hayır

12. HIV ve AIDS konusunda yeterli bilgiye sahip olduğunuzu düşünüyor musunuz?
    A. Evet B. Hayır

13. Bir erkek arkadaşınızın eşcinsel olduğunu öğrenmeniz durumda, onunla görüşmeye devam eder misiniz?
    A. Evet B. Hayır

14. Sizce bir erkeğin evlenmeden önce bir çok eşinin olmuş olması kabul edilebilir mi?
    A. Evet B. Hayır C. Korunmalı cinsel yaşantısı olduysa, evet

15. Sizce bir kadının evlenmeden önce bir çok eşinin olmuş olması kabul edilebilir mi?
    A. Evet B. Hayır C. Korunmalı cinsel yaşantısı olduysa, evet

16. Eğer bir kimse HIV'i almış olabileceğini düşünüyor ve test yaptırmak istiyorsa, bu testi riskli durum veya davranışdan ne kadar zaman sonra yaptırmalıdır?
    A. Riskli davranışından hemen sonra
    B. Bir ay sonra
    C. 3-6 ay sonra
    D. Bilmiyorum

17. Eğer bir hastanız size hastanede HIV pozitif olduğunu söylerse, diş hekimi olarak ne yaparsınız?
    A. Ben bakmam, HIV'in bana bulaşacağından korkarım
    B. Randevuyu erteleyip, doğru bir şekilde tedavi yapabilmek için bilgi edinmeye çalışırım
    C. Uygunsuz davranışlarda bulunan insanların hastalığı olduğunu düşündüğümden, tedavi etmek istemem

D. Standart önlemleri alıp, gerekli tedaviyi uygularım
E. Diğer (açıklayınız).....

IV. Lütfen aşağıdaki bilgilerden sizin için doğru olan seçeneği işaretleyiniz.

18. HIV, aynı telefonu kullanmakla bulaşabilir.
A. Doğru B. Yanlış

19. HIV, el sıkışmakla veya sarılmakla bulaşabilir
A. Doğru B. Yanlış

20. HIV, öksürük veya hapşırık yoluyla bulaşabilir.
A. Doğru B. Yanlış

21. HIV, aynı tuvaleti kullanmakla bulaşabilir.
A. Doğru B. Yanlış

22. HIV, aynı çatal, kaşık, bardak ve tabağı kullanmakla bulaşabilir.
A. Doğru B. Yanlış

23. HIV ile yaşayan kişiler yıllarca, HIV taşıyıcısı olduklarının farkına bile varmayabilirler.
A. Doğru B. Yanlış

24. HIV, doğum öncesi veya doğum sırasında anneden bebeğe bulaşabilir.
A. Doğru B. Yanlış

25. HIV, sivrisinek aracılığıyla bulaşabilir.
A. Doğru B. Yanlış

26. HIV, anneden bebeğe emzirme yoluyla bulaşabilir.
A. Doğru B. Yanlış

27. HIV, aynı telefonu kullanmakla bulaşabilir.
A. Doğru B. Yanlış

28. HIV, korunmasız cinsel ilişki yoluyla bulaşabilir.
A. Doğru B. Yanlış

V. HIV ve AIDS hakkındaki bilgilerinizi nereden edindiniz? (Birden fazla seçeneği işaretleyebilirsiniz)

1. Üniversitedeki derslerden
(Hangi ders olduğunu lütfen belirtiniz.....)
2. Üniversitedeki arkadaşlarımdan
3. Medyadan (Gazete, radio, televizyon, vb.)
4. Lisedeki derslerden
5. Lisedeki arkadaşlarımdan
6. İnternet aracılığı ile
7. Diğer (lütfen açıklayınız)……

FOUR DIFFERENT SCENARIOS IN THE QUESTIONNAIRES

SENARYO 1
Deniz, çocukluğunuzdan tanıdığınız yakın bir kız arkadaşınız. Deniz ile hala arkadaşlığınız devam etmekte ve bir ilaç şirketinde part-time olarak beraber çalışmaktasınız. Deniz kısa bir zaman önce evlendi ve bugüne kadar hayatında eşinden başka hiç kimseyle bir ilişkisi olmadı.

Bugün Deniz ofiste yanınıza geldi ve sizinle çok önemli bir şey konuşmak istediğini söyledi. İş çıkışında beraber bir yere çay içmeye gittiniz. Deniz size dün hastaneye gittiğini, geçen hafta yaptırmış olduğu kan testi sonuçlarını aldığını ve HIV pozitif olduğunu öğrendiğini söyledi. Doktorunun ona virüsü eşinden almış olabileceğini belirttiğini de ekledi. Deniz size, özellikle ofisteki arkadaşlarının onun hakkında ne düşüneceğinden oldukça huzursuz olduğunu söyledi ve bu konuyu sizden sır olarak saklamanızı rica etti.

Deniz ile aynı büroda çalışıyorsunuz, aynı ortamdaki eşyaları, telefonu ve banyoyu ortak kullanıyorsunuz. Deniz'in HIV pozitif olduğunu öğrendikten sonra ne hissederdeniz?

SENARYO 2
Deniz, çocukluğunuzdan tanıdığınız yakın bir kız arkadaşınız. Deniz ile hala arkadaşlığınız devam etmekte ve bir ilaç şirketinde part-time olarak beraber çalışmaktasınız. Deniz'in evlenmeden önce hayatında bir çok erkekle ilişkisi oldu ve kısa bir zaman önce evlendi.

Bugün Deniz ofiste yanınıza geldi ve sizinle çok önemli bir şey konuşmak istediğini söyledi. İş çıkışında beraber bir yere çay içmeye gittiniz. Deniz size dün hastaneye gittiğini, geçen hafta yaptırmış olduğu kan testi sonuçlarını aldığını ve HIV pozitif olduğunu öğrendiğini söyledi. Doktorunun ona virüsü herhangi bir ilişkisinden almış olabileceğini belirttiğini de ekledi. Deniz size, özellikle ofisteki arkadaşlarının onun hakkında ne düşüneceğinden oldukça huzursuz olduğunu söyledi ve bu konuyu sizden sır olarak saklamanızı rica etti.

Deniz ile aynı büroda çalışıyorsunuz, aynı ortamdaki eşyaları, telefonu ve banyoyu ortak kullanıyorsunuz. Deniz'in HIV pozitif olduğunu öğrendikten sonra n

SENARYO 3
Deniz, çocukluğunuzdan tanıdığınız yakın bir erkek arkadaşınız. Deniz ile hala arkadaşlığınız devam etmekte ve bir ilaç şirketinde part-time olarak beraber çalışmaktasınız. Deniz'in evlenmeden önce hayatında bir çok kimseyle ilişkisi oldu ve kısa bir zaman önce evlendi.

Bugün Deniz ofiste yanınıza geldi ve sizinle çok önemli bir şey konuşmak istediğini söyledi. İş çıkışında beraber bir yere çay içmeye gittiniz. Deniz size dün hastaneye gittiğini, geçen hafta yaptırmış olduğu kan testi sonuçlarını aldığını ve HIV pozitif

olduğunu öğrendiğini söyledi. Doktorunun ona virüsü herhangi bir ilişkisinden almış olabileceğini belirttiğini de ekledi. Deniz size, özellikle ofisteki arkadaşlarının onun hakkında ne düşüneceğinden oldukça huzursuz olduğunu söyledi ve bu konuyu sizden sır olarak saklamanızı rica etti.

Deniz ile aynı büroda çalışıyorsunuz, aynı ortamdaki eşyaları, telefonu ve banyoyu ortak kullanıyorsunuz. Deniz'in HIV pozitif olduğunu öğrendikten sonra ne hissederdeniz?

SENARYO 4

Deniz, çocukluğunuzdan tanıdığınız yakın bir erkek arkadaşınız. Deniz ile hala arkadaşlığınız devam etmekte ve bir ilaç şirketinde part-time olarak beraber çalışmaktasınız. Deniz'in evlenmeden önce hayatında bir çok kimseyle ilişkisi oldu ve kısa bir zaman önce evlendi.

Bugün Deniz ofiste yanınıza geldi ve sizinle çok önemli bir şey konuşmak istediğini söyledi. İş çıkışında beraber bir yere çay içmeye gittiniz. Deniz size dün hastaneye gittiğini, geçen hafta yaptırmış olduğu kan testi sonuçlarını aldığını ve HIV pozitif olduğunu öğrendiğini söyledi. Bununla beraber, geçmişte homoseksüel ilişkileri olduğundan da bahsetti. Doktorunun ona virüsü herhangi bir ilişkisinden almış olabileceğini belirttiğini de ekledi. Deniz size, özellikle ofisteki arkadaşlarının onun hakkında ne düşüneceğinden oldukça huzursuz olduğunu söyledi ve bu konuyu sizden sır olarak saklamanızı rica etti.

Deniz ile aynı büroda çalışıyorsunuz, aynı ortamdaki eşyaları, telefonu ve banyoyu ortak kullanıyorsunuz. Deniz'in HIV pozitif olduğunu öğrendikten sonra ne hissederdeniz?